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NORTHWEST HEALTH SERVICES REVIEW

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NORTHWEST HEALTH SERVICES REVIEW
TABLE OF CONTENTS

EXECUTIVE SUMMARY iii

1.0 INTRODUCTION/BACKGROUND 1
- 1.1 Approach 3
- 1.2 The Current Situation 4
- 1.3 Catchment Areas Defined 5
- 1.4 Utilization Patterns 7
- 1.5 Referral Patterns 8
- 1.6 Organization of the Document 12

2.0 HOSPITAL-BASED SERVICES 14
- 2.1 Current Scope of Hospital-based Services and Departmental Operations: Prince Rupert Regional Hospital 16
- 2.2 Current Scope of Hospital-based Services and Departmental Operations: Mills Memorial Hospital 27
- 2.3 Current Scope of Hospital-based Services and Departmental Operations: Kitimat General Hospital 36
- 2.4 Utilization of Hospital Services 47

3.0 REGIONAL SPECIALIST SERVICES 56
- 3.1 Current Profile of Specialist Services 60
- 3.2 Proposed Profile of Specialist Services for the Northwest Region 61
- 3.3 Visiting Specialists 76
- 3.4 Emergency Response Program 77
- 3.5 Critical Success Factors for Regional Specialty Co-ordination 77
- 3.6 Impact Analysis 78

4.0 HOSPITAL MANAGEMENT ISSUES 80
- 4.1 Organizational Structures and Management Responsibilities 80
- 4.2 Nursing Services 82
- 4.3 Labour Relations 85
- 4.4 Education Services 87
- 4.5 Internal and External Working Relationships 88
- 4.6 Working Relationships with the Ministry of Health 91
- 4.7 Recent Operational Reviews 92

5.0 COMMUNITY-BASED SERVICES 94
- 5.1 Continuing Care 97
- 5.2 Public Health 98
- 5.3 Mental Health 99
- 5.4 Alcohol & Drug-related Services 99
- 5.5 Rehabilitation Services 102
- 5.6 Seniors' Services 103
- 5.7 Consultation and Co-operation 104

6.0 IMPROVED CO-ORDINATION OF HEALTH PROGRAMS 107
  6.1 Analysis of Issues 108
  6.2 Alternate Approaches to Existing Delivery Structures 109
  6.3 Analysis of Alternatives 112
  6.4 Implementation 114

7.0 CONCLUSIONS 115
  7.1 Listing of Recommendations 118
  7.2 Listing of Suggestions 126

ADDENDUM HEU Letter

LISTING OF TABLES

Table 1 1990-91 Age Standardized Utilization Rate for Selected LHAs 11
Table 2 Hospital Utilization by Place of Residence, 1990-91: Percentages of Total Inpatient Cases by Hospital 12
Table 3 Referral Patterns by Local Health Area, 1990-91: Percentage of Total Local Health Area Care Received by Hospital 14
Table 4 Hospital Services in Prince Rupert, Terrace, and Kitimat 18
Table 5 Distribution of Specialists and General/Family Practitioners in the Communities of Prince Rupert, Terrace, and Kitimat 63
Table 6 Appropriate Specialist/Population Ratios for the Northwest Region 65
Table 7 Range of Community-based Services Provided in the Northwest Region 99

APPENDICES

Appendix 1 List of Scheduled Community Presentations
Appendix 2 Map of Local Health Areas

EXECUTIVE SUMMARY

In the summer of 1992, the Minister of Health commissioned a study of health services currently being provided in the Northwest sector of the province. The need for this study was precipitated by concerns expressed by citizens in the communities of Prince Rupert, Terrace, and Kitimat regarding anticipated bed closures and service reductions resulting from funding restrictions in the 1992-93 budget allocations.

A seven-member Review Team, comprised of three hospital management representatives and a management consultant appointed by the Ministry of Health and three representatives appointed by each of the three major health care unions, was established to conduct this review.

The Review Team visited the area in early September 1992. Working in co-operation with the local health action committees and the administrator representatives of the health care providers, the Team met with representatives from various health care agencies and received presentations from community groups and interested citizens.

The Team was asked to recommend appropriate service utilization rates which might be expected in each of the communities and to identify the appropriate location of special programs which received referrals from a broad regional catchment area. In addition, the Team was asked to consider changes to the current way of delivering services to enhance provision of the highest quality health care in the Northwest region. It was recognized that the review of existing services be conducted and recommendations made within the industry context of limited available resources.

Throughout the review, the Team identified a number of specific operational issues within each of the acute care hospitals, relating either to departmental activities, management directions, or organizational structures. These matters were addressed and, wherever appropriate, specific recommendations made.

With respect to labour relations, the Review Team addressed a number of concerns including the need for improved co-ordination of human resource activities within each of the hospitals and the need for improved education and training programs throughout the area. Also addressed was the issue of position deletions and staff layoffs. The Team strongly recommends no further layoffs unless a labour adjustment strategy is in place to provide support to displaced employees. There appear to be opportunities for staff relocation and retraining within the area; the realization of these opportunities is dependent on effective communication between the various health care providers and the formalization of a program to carefully plan and manage staff displacement.

The Review Team identified a number of problems in each of the communities associated with the utilization of the acute care facilities. It noted that current utilization patterns for each of the hospitals (based upon patient days per age/sex adjusted population base) was approximately twice as high as the provincial average. A number of areas were identified where specific changes could be made to significantly improve hospital utilization and provide effective care with fewer inpatient beds.

The Team identified the existing scope and level of specialty services being provided and analyzed the ability of the catchment area to support and sustain additional specialty services. It concluded that there should be increased specialty services in the areas of general surgery, general medicine, paediatrics, ophthalmology, anaesthesia, radiology, laboratory medicine, and psychiatry. The need for improved utilization of specialty services on a regional basis was also noted, along with the ongoing use of visiting specialists in the area.

The Review Team also addressed the current levels of service being provided by various community-based health agencies. Three major areas of concern were identified, namely, levels of service provided by alcohol and drug services, rehabilitation services, and social services. The Team identified specific adjustments for both social services and rehabilitation services to return these areas to acceptable staffing levels. Other recommendations include improvement in the provision of alcohol and drug treatment in the area.

A number of problems were also identified with respect to co-ordination of community-based services and to communication between the health care providers within the communities. Significant opportunities were noted in each of the communities for improved utilization management through better discharge planning. In particular, the Team noted in each of these areas the important role of the medical staff to actively support improved discharge planning and more effective utilization of hospital beds and community-based health services.

The Review Team concluded that there are many areas where significant savings in existing resources could be realized through improved utilization, enhanced discharge planning, better management, and improved co-ordination of health services. The Team has suggested that, if these areas are properly addressed and the subsequent savings realized, there may be considerable funds available to be transferred to those programs and services requiring additional resources while still maintaining required services in the region.

Finally, the Review Team reviewed various opportunities for improved co-ordination of health care services within the Northwest. It concluded the development of community-based health councils on a short-term basis would provide the opportunity for significant improvements in overall co-ordination of health care delivery in the area. The Team also supported the eventual development of a regional health council. However, due to existing parochial interests and localized needs, the Team felt it would be most appropriate to begin health co-ordination at a community level, expanding it to a regional basis at a later date. Lastly, assignment of a regional co-ordinator to the area (under contract from the Ministry of Health for a 2 to 3 year period) would facilitate the promotion, co-ordination, and implementation of recommendations arising from this review. A listing of the recommendations made in this report are included with the Conclusions (Section 7.0)

1.0 INTRODUCTION/BACKGROUND

The Northwest Health Services Review, commissioned by the Minister of Health in the summer of 1992, was requested to address issues relating to the accessibility of adequate levels of health services in the Northwest region of the province.

Since there was considerable concern in the communities regarding bed closures, perceived service reductions, and potential staff layoffs, the Minister established a Review Team to look at these and related issues in Prince Rupert, Kitimat, and Terrace. The Review Team was composed of representatives from hospital management, management consulting, and the three major health care unions in the province (HEU, HSA, and BCNU). Thus, the Review Team consisted of four management representatives appointed by the Ministry of Health, and three representatives appointed by their respective unions. They are as follows:

Mr. Bert Boyd	Health Management Consultant
Mr. Dennis Cleaver	Executive Director, Prince George Regional Hospital
Ms Jennifer English	Assistant Executive Director of Patient Care, Saint Mary's Hospital
Ms Kathy McLennan	Senior Labour Relations Officer, Health Sciences Association of B.C.
Ms Bella Maud	Staff Representative, Hospital Employees' Union
Dr. Philip White	Chief of Staff, Kelowna General Hospital
Ms Leslie Zinger	Registered Nurse, representing B.C. Nurses' Union

The Ministry of Health, in its funding allocation to hospitals in 1992-93, considered inpatient utilization patterns within hospitals based upon the size and type of population being served. In developing the funding formula for the fiscal year, the Ministry determined that any acute care hospital having an inpatient bed utilization rate (based upon patient days per age/sex adjusted population) which exceeded 150 percent of the provincial norm would not receive a funding adjustment. The stated intention of the Ministry was for hospitals having such high utilization rates to take whatever steps were necessary to reduce overall utilization and thus bring expenditure patterns back within levels being experienced by peer group hospitals.

As a result of this revised funding formula, many hospitals in the northern part of the province, including the Prince Rupert Regional Hospital, Kitimat General Hospital, and Mills Memorial Hospital at Terrace did not receive their anticipated funding adjustment.

In response to funding restrictions in the 1992-93 budget allocations, Kitimat General and Mills Memorial Hospitals reacted by closing beds (some of which were not actively used). Prince Rupert Hospital anticipated bed closures. The combination of factors relating to bed closures, perceived service reductions, position deletions, and staff layoffs created considerable anxiety within each of the communities with respect to their ongoing access to adequate levels of health care. As a result, Local Health Action Committees were established by the three unions with a broad base of community representation. These Health Action Committees became a focal point for identifying health-related concerns within each of the communities. They subsequently became actively involved with the Review Team in establishing community forums and making representation to the Team.

In accordance with the Terms of Reference for this study, the Review Team was asked to undertake the following:

- Review and analyze health care services, especially hospital-based services (including their volumes) which currently exist in the three major regions (Prince Rupert, Kitimat and Terrace), with respect to the needs of the local population.

- Identify duplication or overlap of services and make recommendations to improve consultation and co-operation within the region both between hospitals and between hospitals and community-based services.

- Recommend:
    - appropriate service utilization rates which might be expected in each community, recognizing the current funds available;
    - the appropriate location of special programs (i.e., those with a broad regional base); and
    - changes to services or the way services are provided to ensure the highest quality of health care in the Northwest region, consistent with available funds.

1.1 APPROACH

The Review Team members agreed to group the Terms of Reference into four major areas:

- Assessment of appropriate levels of specialty services to be offered in the region; identification of the optimal approach to offering these services.
- Analysis of the effectiveness/appropriateness of existing hospital activities.
- Review of the adequacy of community services currently being provided.
- Identification of opportunities for improved regional co-ordination with analysis of the impact on the management and provision of health care in the area.

The Review Team assigned responsibilities to members of the group in accordance with this division of the Terms of Reference. To commence the process, the Team met twice with an outside facilitator to confirm the Terms of Reference, to receive a report from the Ministry of Health, and prepare a workplan for the review.

The Review Team visited the Northwest area from August 30 to September 3, 1992, inclusive, and met with community health, hospital, medical, private practice and civic representatives. In addition, community sessions were held each evening in the three communities where interested groups and individuals were given the opportunity to make presentations to the Team. These sessions were jointly co-ordinated by the local Health Action Committee and the hospital administration and were chaired by the Chairperson of each Health Action Committee. A list of presenters at these sessions is included at Appendix 1.

The Review Team found the four days of on-site visits to be most beneficial, due in a large part to the support offered by all health care representatives in the area. The Team would like to thank the respective hospital administrations who co-ordinated schedules and arranged meetings as requested; the Chairs of each Health Action Committee for their work in co-ordinating the community sessions; and all those who took the time to meet with Team members.

1.2 THE CURRENT SITUATION

The Review Team identified a number of themes which were being consistently presented throughout the on-site visits. The following represent the major concerns expressed by health professionals, community representatives and concerned citizens throughout the Pacific Northwest:

- Concern over potential reduction in the provision of acute care services because of current funding restrictions, particularly with respect to the provision of specialty services.
- A perception that the reduction in the number of acute inpatient beds necessarily minimizes the hospital' ability to provide adequate levels of service.
- Concern over the current availability of sufficient community-based health services to adequately meet the needs of the community, and concerns that bed closures were occurring before the enhanced community services were established.
- A belief that the Ministry of Health's current funding system penalizes northern and isolated hospitals.
- Concerns about the inordinate costs and travel difficulties in obtaining care in Vancouver or in other major centres.
- Concerns regarding the difficulties of travel in the Northwest in adverse weather conditions.

Many of these themes were expressed repeatedly at each of the community sessions. The Review Team could not help but notice that at the evening sessions, and particularly in Kitimat and Terrace, the speakers focused primarily on acute care inpatient needs and were particularly concerned about any loss of specialized services.

The Team was impressed with the degree of enthusiasm and support for each local hospital in its community. However, it was frequently noted that this enthusiasm was being utilized to fuel rhetoric and negative impressions with regard to the hospital's funding. There is no doubt that health care is very important to the residents of the Northwest but that little attempt has been made to date to address some of the major utilization and service delivery issues in these communities. These issues notwithstanding, good ideas were presented, albeit in a formative stage. Each community certainly values maximizing opportunities to improve management effectiveness and overall utilization of health care services.

It was very clear during this review process that there was a fundamental lack of understanding of health care budgeting and funding, both by health care professionals and citizens within the community. Furthermore, it was noted that minimal effort has been made to educate these groups with regard to the way hospitals are funded. For example, the Team frequently heard quotes such as "providing services in the small hospitals at $400 per day is less expensive than providing services in Vancouver at $800 per day". These comparisons are limited without any reference to identifying costs per case-type. There also appears to be considerable misunderstanding over the Ministry of Health's approach to funding hospitals in 1992-93, taking into consideration both the over utilization of facilities and the funding requirements to cover negotiated pay increases.

1.3 CATCHMENT AREAS DEFINED

The Review Team recognized the need to clearly define the population base that would serve as the primary catchment area for the hospitals so that specific recommendations could be made regarding the types of specialty services that could be based in this area. It was agreed that the population estimates for each of the Local Health Areas would be taken from data produced by the Planning and Statistics Division of the Ministry of Finance and Corporate Relations, and presented in *Population Extrapolation for Organizational Planning with Less Error* (P.E.O.P.L.E. 17).

The Review Team agreed, after a review of the boundaries for existing regional hospital districts, health units, and local health areas in conjunction with an assessment of the referral patterns in the area, that the following local health areas be considered as the primary catchment area for the region under review:

Local Health Area	**1991 Population**
#50 - Queen Charlotte	5,405
#52 - Prince Rupert	17,850
#80 - Kitimat	11,919
#88 - Terrace	25,233
#92 - Nishga	1,572
#94 - Telegraph Lake	776
	62,755

NOTE: See map (Appendix 2) for location of each LHA.
Source: P.E.O.P.L.E. 17, Planning and Statistics Division, Ministry of Finance and Corporate Relations.

These six Local Health Areas overlap with two Regional Hospital Districts, namely the Skeena-Queen Charlotte and the Kitimat-Stikine. The Skeena Health Unit has responsibility for programs in all six Local Health Areas plus adjoining areas. This overlap in areas between the various planning agencies and service providers was noticed to be detrimental in the provision of health care in the area in that it created significant problems in planning in an integrated fashion.

The P.E.O.P.L.E. 17 document identifies projected population growth for these six LHAs of approximately 10 percent by the year 2000. This means that the health care system would be required to have the capability to serve approximately 70,000 residents by the end of this decade.

It is interesting to note that throughout the on-site visits, the Review Team was being advised that populations of anywhere from 85,000 to 115,000 represented the catchment area in the Northwest. The extent of this variance of perception over reality obviously heightens area residents' expectations concerning the ability of the area to sustain specialty services.

1.4 UTILIZATION PATTERNS

The population profiles of the area served by each of the three hospitals are similar, except that Prince Rupert has a substantially higher native population than the other two centres. However, the population profiles are significantly different from those found in much of the rest of British Columbia, in that the population is relatively young, with six percent or less of the population being over 65 years in age, as compared to a provincial average of thirteen percent. This differential is particularly important given the fact that young people overall have a lower utilization rate of acute care facilities than do the elderly.

It is recognized that there could be at least a partial offset to this variance in utilization since some patients are from remote communities within the catchment area. These patients may require hospitalization at a lower threshold because they are unable to be discharged without home support or follow-up observation. Furthermore, disproportionately high rates of teenage pregnancy, sexually transmitted diseases, substance abuse and family violence in these communities place greater demands on the health care system.

Utilization rates of inpatient beds in this area are significantly higher than most other areas in the province. Table 1 outlines these utilization patterns, adjusted on an age standardized basis, as compared to other areas in the province.

Table 1

1990-91 AGE STANDARDIZED UTILIZATION RATE FOR SELECTED LHAs[1]

LHA	AGE ADJUSTED DAYS PER 1,000 POPULATION
50 - Queen Charlotte	1,596
52 - Prince Rupert	1,750[1]
80 - Kitimat	2,388
88 - Terrace	1,705
92 - Nishga	2,005
94 - Telegraph Creek	1,336
Provincial Average	970

NOTE: 1. Adjusted from original figure of 1,910 to 1,750 taking into consideration there were three long-term care patients occupying acute care beds.
Source: Ministry of Health document based on 1990 standard population.

The age-adjusted days for each of these LHAs is considerably higher than utilization rates for institutions in other parts of the province offering similar health care services. For example, comparative figures for Quesnel equate to 1,337 age-adjusted days per 1,000 population and 1,128 and 970 respectively for the communities of Nelson and Salmon Arm.

1.5 REFERRAL PATTERNS

In analyzing the referral patterns for inpatient activity, it is important to consider both the utilization of hospitals within the area and the referral patterns to other regions within the province.

Use of Area Hospitals

The extent to which patients are "referred in" to a hospital can be identified by analyzing the percentage of cases in a hospital by place of patient residence. This information is presented in

Table 2 for each of the hospitals in this area. It indicates, for example, that 85.5 percent of inpatients at Prince Rupert Regional Hospital in 1990-91 lived in the Prince Rupert LHA and that only 1.1 percent came from the Terrace LHA. The remaining 13.4 percent came from outside these two LHAs. Similarly, 96.3 percent of inpatients at Kitimat were from the Kitimat LHA, which means that only 3.7 percent of patients came from outside the LHA. Terrace figures indicate 86.1 percent of their inpatient cases were from the LHAs of Terrace and the neighbouring areas of Nishga and Telegraph Lake, and that 13.9 percent came from outside these LHAs.

Table 2

**HOSPITAL UTILIZATION BY PLACE OF RESIDENCE, 1990-91
PERCENTAGES OF TOTAL INPATIENT CASES BY HOSPITAL**

RESIDENCE OF HOSPITAL INPATIENTS	PRINCE RUPERT	MILLS MEMORIAL	KITIMAT GENERAL	STEWART GENERAL	QUEEN CHARLOTTE	WRINCH MEMORIAL
LHA 50-Queen Charlotte	3.8%	0.1%	0.1%	0.0%	91.2%	0.0%
52-Prince Rupert	85.5	2.7	0.1	0.0	0.1	0.2
80-Kitimat	4.1	3.1	96.3	0.0	0.0	0.0
88-Terrace	1.1	78.4	0.7	73.2	0.1	92.7
92-Nishga	2.0	5.8	0.1	0.0	0.0	0.0
94-Telegraph Lake	0.0	1.9	0.0	0.0	0.0	0.4
Total % Inpatients Residing in Catchment Area	96.5	92.0	97.3	73.2[1]	91.4	93.1

NOTE: 1. Significant coding problem with undefined B.C. area cases results in disproportionately low figure.
Source: Ministry of Health Report (6) – LHA Referral Patterns by Hospital

From the above table the following is noted:

- The vast majority of inpatients under care at all of the hospitals are from their own, or immediately adjacent, Local Health Area, i.e., there is minimal referral from one Local Health Area to another.

- There is greater referral to Prince Rupert from Kitimat than from Terrace (4.1% vs. 1.1% of Prince Rupert's cases).

In assessing movement of patients within the Northwest, the issue was raised as to the impact of Smithers residents on the workload for this area. In fact, only 2.9 percent of Mills Memorial's patients and 3.5 percent of Wrinch Memorial's patients came from the Smithers LHA. In the other hospitals, less than 1.0 percent of their patients were from the Smithers LHA.

Referrals to Other Hospitals

As mentioned, it is also important to analyze the referral patterns from a specific LHA to other hospitals in the province. The information for the six LHAs in this area is presented in Table 3. For example, 83.1 percent of patients residing in the Prince Rupert LHA received care at their local hospital, and a further 11.1 percent received care at the Vancouver teaching hospitals. The remaining 5.8 percent received care at numerous other hospitals.

Table 3

REFERRAL PATTERNS BY LOCAL HEALTH AREA, 1990-91
PERCENTAGE OF TOTAL LOCAL HEALTH AREA CARE RECEIVED BY HOSPITAL

HOSPITAL	LHA 50 QUEEN CHARLOTTE	LHA 52 PRINCE RUPERT	LHA 80 KITIMAT	LHA 88 TERRACE	LHA 92 NISHGA	LHA 94 TELEGRAPH LAKE
Prince Rupert Regional	14.6%	83.1%	6.1%	0.9%	20.5%	0.9%
Mills Memorial	2.0	2.5	4.5	64.9	65.1	75.2
Kitimat General	0.1	0.1	72.4	0.3	0.3	0.1
Queen Charlotte	52.7	0.1	0.1	0.1	0.0	0.0
Stewart General	0.0	0.0	0.0	1.7	0.0	0.0
Wrinch Memorial	0.0	0.1	0.0	18.9	0.0	4.4
COUTH Hospitals[1]	23.1	11.1	11.3	8.2	10.3	8.9
Other	7.5	3.0	5.6	5.0	3.8	10.5
	100.0	100.0	100.0	100.0	100.0	100.0

NOTE: 1. COUTH (Council of University Teaching Hospitals) include Vancouver General, St. Paul's, University, B.C.'s Children's, Grace, G.F. Strong, B.C. Cancer Agency, and Sunny Hill.

Source: Ministry of Health Report 6 – Acute/Rehab. Volume by Residence of Patient.

It is interesting to note from Table 3 that:

- Referrals from each of the LHA's to the Vancouver teaching hospitals range consistently from 8-11 percent, with the exception of the Queen Charlotte's (23.1%).

- Referrals from the Queen Charlotte's to Prince Rupert Regional Hospital are less than might be expected, given their proximity.

- There are fewer referrals of cases from Kitimat to Terrace (4.5%), even with its larger specialty base, than there are referrals to the more distant Prince Rupert (6.1%).

As noted, referrals from the northern hospitals to the Vancouver teaching hospitals were generally in the 8-11 percent range. It is interesting to compare these referral patterns to those from other

Local Health Areas representing similar types of hospitals and/or areas of isolation, namely, Dawson Creek, Fort St. John, Quesnel, and Williams Lake. These communities have referral rates to the COUTH hospitals ranging from 6.5 percent to 8 percent. They also refer to other regional centres (e.g., Prince George Regional Hospital and Royal Inland Hospital in Kamloops) for an additional 4-10 percent of their inpatient cases. Consequently, the overall referral rates from these outlying areas of the province to specialized services in other communities is in fact higher than that experienced in the Northwest communities.

1.6 ORGANIZATION OF THE DOCUMENT

This document has been organized in seven major sections as follows:

Section 1

This section is an introduction to the review, and as such identifies the scope of the study and the demographic profile of the area under review.

Section 2

In this section the current scope of hospital-based services and departmental operations for Prince Rupert Regional Hospital, Mills Memorial Hospital, and Kitimat General Hospital are outlined. It includes a description of each organization and an analysis of hospital utilization. It concludes with a discussion of opportunities for enhancing use of hospital resources.

Section 3

Section 3 presents the current and proposed profile of Specialist Services for the Northwest Region. It discusses physician/population ratios for the area based on Ministry of Health Guidelines. In addition, it identifies service areas where visiting specialists (from outside the area) are required to supplement specialists based in the region.

Section 4

This section summarizes a number of hospital management issues arising from the review. It includes discussion of management/administrative responsibilities, labour relations issues, education, internal and external working relationships, and relationships with the Ministry of Health.

Section 5

In this section community-based services with respect to Continuing Care, Public Health, Mental Health, Alcohol and Drug, Seniors' Services, and Rehabilitation Services are reviewed . It includes observations and comments on opportunities for greater consultation and co-operation between service provider organizations.

Section 6

Section 6 identifies a number of issues related to improved co-ordination of health programs from an individual community and regional perspective. Several alternate models for improved service co-ordination are presented.

Section 7

This section summarizes the opportunities, within available funding, for enhancement of health services in the Northwest which would result from improved strategies of utilization management and community/institutional partnerships. It concludes with a full listing of suggestions and recommendations made throughout this report.

2.0 HOSPITAL-BASED SERVICES

This section outlines the current scope of hospital-based services and departmental operations for Prince Rupert Regional Hospital, Mills Memorial Hospital, and Kitimat General Hospital. It includes a description of each organization and an analysis of utilization of services. It concludes with a discussion of opportunities for enhancing use of hospital resources.

There are six hospitals in the area offering acute care services. Of these, the hospitals at Stewart, Queen Charlotte and Hazelton are smaller than the others and, apart from Ophthalmology services offered in Hazelton, restrict their services to the immediate communities. They tend to use the three larger hospitals at Prince Rupert, Terrace, and Kitimat as referral hospitals for their more complex cases. Both Prince Rupert Regional Hospital and Mills Memorial Hospital are considerably larger than Kitimat and offer a broader range of services (except for Orthopaedics which is sited in Kitimat).

Table 4 details the number of beds set up in the Prince Rupert Regional, Mills Memorial, and Kitimat General Hospitals. The table also outlines summary activity data for 1991-92 with respect to number of admissions, average length of stay, number of operating room visits, operating expenditures, and other overview activity.

Table 4

HOSPITAL SERVICES IN PRINCE RUPERT, TERRACE, AND KITIMAT

BEDS SET UP (AS OF SEPT. 1/92)	PRINCE RUPERT REGIONAL	MILLS MEMORIAL-TERRACE	KITIMAT GENERAL
Medical	27 + 3 LTC	30	11
Surgical	23		12
Intensive Care Unit	4	3	2
Paediatric	10	6	4
Maternity	10	18	5
Psychiatric	0	10	0
Total Acute/Rehab.	77	67	34
Extended Care Unit	23	20 (Terrace View Lodge)	29
Long Term Care	50 (Acropolis Manor)	65 (Terrace View Lodge)	6
1991-92 Activities			
Admissions - Acute/Rehab. - Newborn	3,782 356	4,522 440	1,868 169
Average Length of Stay - Acute/Rehab. - Newborn	5.43 3.79	4.36 4.12	4.75 4.48
% Occupancy - Acute - Extended Care	74.1 99.4	83.0	56.4 91.1
Operating Room Visits	1,895	2,905	856
Emergency Visits	14,386	19,871	N/A
Weighted Patient Days (W.P.D.)	45,065	43,598	24,583
Operating Expenditures	$13,995,000	$12,547,500	$8,383,188
Op. Exp./W.P.D.	$311	$288	$341

Source: Ministry of Health Hospital Comparison Report, 1991-92.

2.1 CURRENT SCOPE OF HOSPITAL-BASED SERVICES AND DEPARTMENTAL OPERATIONS: PRINCE RUPERT REGIONAL HOSPITAL

Prince Rupert Regional Hospital is one of the most northerly hospitals with Specialist Services in British Columbia. It is located at the end of Highway 16 in the city of Prince Rupert and serves a local catchment area of 18,000 people with a further catchment of around 5,500 from the Queen Charlottes. Prince Rupert is an important, small industrial city with major industries in shipping, fishing, lumber and tourism. The community base has been stable for many years with low population growth over the last few years and a projected growth of approximately 10 percent in the next ten years. At certain times of the year, particularly in the summer, Prince Rupert's population can vary due to the arrival of cruise ships, fishing fleets and tourists.

Prince Rupert Regional Hospital has an approved acute/rehab bed capacity of 101 beds. Seventy-seven beds are set up at the present time although the actual number in operation during the summer was 65 due to summer bed closures, initiated on June 26, 1992. The hospital's occupancy on an annual basis is low and even with the summer bed closures, the average occupancy level is rarely greater than 75 percent. Moreover, waiting times for beds and procedures are short with a virtually non-existent surgical waiting list.

Primary and secondary medical and surgical services are offered at Prince Rupert Regional Hospital including: Internal Medicine, General Surgery, Obstetrics and Gynaecology, Radiology, Anaesthesia, General/Family Practice, and Emergency Medicine. Dental Surgery is also performed at the hospital. These services are augmented with visiting specialists in Urology, Paediatrics, Ophthalmology, Dermatology, Rheumatology, Neurology, Psychiatry, Plastic Surgery, Orthopaedic Surgery, and Oncology.

The hospital is also providing outpatient services in dietary diabetes, stress testing, Physiotherapy, Laboratory and Diagnostic Imaging, fetal monitoring with non-stress testing, pre-natal education, and Psychiatry. Pharmacy Services are provided to the Kitimat General Hospital and the Nishga Valley Health Board.

2.1.1 Medical Staff

There are 17 family physicians, of which six practice Anaesthesia, one Cardiac Stress Testing, and one part-time General Surgery. The specialist staff consists of an Internist/Intensivist, a General Surgeon, and a Radiologist. An Obstetrician/Gynaecologist has recently left but another has been recruited effective January, 1993.

2.1.2 Administration

The current organization chart for Prince Rupert Regional Hospital is dated June 1992. The number of Directors reporting to the Chief Executive Officer is not excessive.

Significant changes have occurred in the Administration of the hospital in the past year or so. These changes include the departure of the previous Chief Executive Officer, followed by an interim CEO and the appointment of the current CEO (on-site for approximately five months). Considerable time was spent with the new CEO who seemed to have acquired an understanding of the hospital, its funding base, and the difficulties experienced with operations. It should be noted that although morale at the hospital is not good, many staff recognize the changing circumstances of the hospital and are looking to the Chief Executive Officer to provide the needed leadership.

The new Director of Finance and Management Information Systems has been with Prince Rupert Regional Hospital since May 1992. A cash flow projection to the year end March 31, 1993 has been developed. The hospital anticipates "operating funds will most probably be depleted by some time in December 1992." The hospital has projected a deficit in excess of $750,000 for the current fiscal year.

2.1.3 Nursing Services

It was observed that Prince Rupert has a motivated, skilled nursing staff operating with a higher focus on critical care as compared to the nursing staff at the other hospitals in the area. Morale in this area was reported to be high.

There are currently 10 nursing areas with six Head Nurses responsible for a total of 77 acute beds (in use) and 23 extended care beds. There are five emergency stretchers and two Operating Rooms. Ambulatory Care-type procedures are performed in the Emergency Department and daycare surgery patients occupy four stretchers in the Surgical Unit.

For the first time in several years there are no full-time vacancies and pre-booked overtime has disappeared in most units. Overtime does, however, remain a problem for the Operating Room and ICU. Surgical bookings on weekends and after hours result in overtime for the regular staff because of the lack of skilled casuals. This raises the question about the need for the after hours and weekend surgical bookings.

Visiting specialists also create a high demand for operating time and increase the amount of overtime required. Replacements for sick and vacation relief remains difficult in these areas. Historically, Prince Rupert has been forced to combine units and close beds to enable staff to take summer vacation. This summer, however, the hospital worked "short" and placed staff on call.

The deletion of the Nursing Supervisor positions raises the issue of "who is in charge?". The Physicians, for the most part, initiate the call-back/call-in of Operating Room Nurses after hours and on weekends. The Operating Room recruited a new Head Nurse (effective on July 1, 1992) who has a history of having worked in Paediatric ICU, Emergency and Operating Rooms in a similar type rural hospital in St. Johns, New Brunswick where restrictions were placed on Physicians with regard to availability of nursing manpower.

Difficulties with casual staff were revealed here as in other hospitals in the Northwest because Nurses in these rather remote northern communities want a guarantee of regular hours. The long-term possibility of attracting casual staff remains poor. This may be due in part to poor management of resources, as the reaction to bed reduction seems to be to layoff full-time staff. A more flexible option would be to employ staff as permanent part-time who would then be available for casual relief. In the Labour and Delivery area, the Head Nurse has partially resolved this issue by splitting full-time positions into permanent part-time positions. This strategy has increased the number of skilled Maternity Nurses available for extra work and gives more flexibility to the system. The College in Terrace has provided short-term availability of new graduates. Stronger ties will need to be forged between Prince Rupert and the College. The new two-year program will give the Northwest a larger resource pool of Nurses and the opportunity for more individuals to train locally in the profession.

The Head Nurse of the Emergency and Intensive Care Units has recently been recruited from the United States (July 1992). The incumbent's previous experience as an instructor in Critical Care will be of significant benefit to Prince Rupert where higher level Internal Medical and General Surgical services are offered. The Head Nurse believes there is a need for a clinical teacher separate from the Head Nurse to provide adequate training and skill teaching for staff. Transfer of medical functions and skill certification is an important requirement for those areas. Sponsored by the hospital, the Nurses in Emergency and ICU have been trained in Advanced Cardiac Life Support. Many of the Nurses in this area have also taken critical care courses on their own, reinforcing the perception of an enthusiastic, highly motivated, skilled staff with a leaning towards self-improvement.

The hospital has a well-organized education program in place for individuals impacted by transfer of function. The program includes annual re-certification of skills, placing emphasis and importance on education both for acquisition and maintenance of skills. Several Nurses are certified as "teachers" for transfer of functions. The Infection Control/Education Co-ordinator has no clinical responsibilities and is not considered a clinical resource by staff. The main responsibility of this position with respect to education is to arrange the "calendar" of inservices which are provided on a regular basis. Topics are usually decided on by the staff and arrangements are made by the co-ordinator. Inservices are given by the physicians.

The lack of flexibility by Administration in the use of the Nursing resource is also demonstrated in the rigid staffing structure which prevents the development of skills in areas where they may be required. At the present time, most Nurses are isolated on their units with each unit becoming more specialized.

Since the elimination of the Supervisor positions, who acted as a Float Nurses at times, the staff believe that overtime costs have substantially increased due to lack of co-ordination between wards with regard to staff utilization and workload. It has been proposed on several occasions that developing Float Nurses with the appropriate skills on each shift will address many of the workload and call-back issues. This system is highly effective and relevant to a hospital the size of Prince Rupert. The Head Nurses share an on-call roster for after hours and weekends. This system is felt to be inefficient and expensive. Not only is the Head Nurse paid two hours for every call (without having to go into work) but the Head Nurses are also frequently unfamiliar with the other Units and lack the required skills. This results in a tendency to authorize the call-back/call-in of the regular staff. It is suggested that the hospital develop a pool of Float Nurses to reduce the need for call-back and call in and to assist in the retention of skilled Nurses.

2.1.4 Surgical Nursing Unit

The Surgical Nursing Unit consists of 23 inpatient beds with four day-care surgery surgical stretchers and a current utilization of 66 percent. This has remained constant over the past three years. During the summer there is a planned reduction to 19 beds.

There are approximately four surgical day-care cases admitted per day. In many institutions, day-care beds are turned over twice per day. The Unit appears to operate smoothly with a well-trained and enthusiastic Nursing Staff.

2.1.5 Medical Nursing Unit

The current Medical Unit consists of 25 beds and two Telemetry beds. This Unit is also used to look after acute Psychiatric patients. Occupancy levels on the unit are 82 percent. Planned closures in the summer reduce the number of beds to 17. The Telemetry beds are counted as part of the Medical Unit but are actually staffed by ICU staff. The ICU occupancy of their four beds is 48.3 % and they can accommodate the additional Telemetry workload.

2.1.6 Maternity Unit

There are 10 Maternity beds, 19 Bassinets, and two Labour Rooms with no Birthing Rooms. The Unit has an average occupancy rate of 58.5 percent with Bassinet use of 18.7 %. Caesarean sections are performed in the Operating Room and high risk antepartum patients are transferred to the Lower Mainland prior to delivery, as are high risk babies, after stabilization at the hospital. Little use is made of the Paediatric service in Terrace.

2.1.7 Paediatrics

The Paediatric Unit has 10 beds with a Head Nurse who is also responsible for the 23-bed Extended Care Unit. Occupancy of the Paediatric Unit is surprisingly high at 84.8 percent. This high occupancy rate reflects the usage of these beds by Medical and Surgical "overflow" patients, as well as Paediatric patients. Review of admissions to the Paediatric Unit suggests that a significant number may not require intensive hospital resources. Diagnoses were noted relating to "fever", upper respiratory tract infection (non-croup requiring no medical or nursing care), and gastroenteritis (with no evidence of formal fluid replacement programs or intravenous). Again, the question of distance from the hospital for remote communities may necessitate some of these admissions, but the majority were, in fact, from the local area.

2.1.8 Intensive Care Unit

The Intensive Care Unit has four beds with two adjacent Telemetry beds included in the Medical Unit bed count but staffed by the ICU Nurses. 4.2 FTE Registered Nurses work on this unit sharing a Nurse Manager with Emergency. Staff rotate through both Emergency and ICU. The ICU occupancy rate, as previously noted, was only 48.3 percent to date for 1992. The Unit is used on occasion for pre- and post-operative surgical patients and some high level Internal Medicine monitoring processes.

2.1.9 Extended Care Unit

The Extended Care Unit has 23 beds set up and uses three extra beds in the Medical Unit for "holding" assessed patients and those waiting placement to intermediate care homes. The Unit's atmosphere appears excellent and is well-run. Its occupancy of 99.5 percent is consistent with other units of this type in the province.

2.1.10 Operating Room and PAR

The hospital runs two Operating Rooms, five days a week, with cases starting at 0830 hours and ending at approximately 1330-1440 hours, occasionally re-starting at 1730 hours. The Nurses, however, are scheduled to work an 8-hour day and are on a call-back schedule for emergency and add-on cases. In 1991, 1,776 procedures were done in the Operating Room and considerable overtime was used.

One rather unique problem seems to be that the General/Family Practitioner Anaesthetists who work at the hospital are, for the most part, available only in the morning. They have afternoon offices and are not available again until late in the afternoon for add-on or emergency cases. There seems to be no criteria for emergency or add-on cases; a review of these suggests that some are not true emergencies. This causes problems with casual and full-time staff with excessive use of overtime and sick time, and eventual burn-out.

The hospital has the responsibility to ensure its Operating Room resources are used in an efficient manner.

It is recommended that:

- **The Administration and Medical Staff at Prince Rupert Regional Hospital discuss effective utilization of the Operating Rooms in an open manner and that the hospital develop an OR booking system that will meet mutual needs.**

2.1.11 Emergency Department

The Emergency Department has five stretchers and is staffed by 4.2 FTE Registered Nurses with the Head Nurse shared with the ICU.

In 1991-92, the Emergency Department had 17,644 visits (including minor surgeries, follow-up visits, and ambulatory care-type procedures). Even though this is a substantial number of visits for a city of this size, the level of staffing appears adequate for this volume. It is noted that the Physicians sometimes use the Emergency Department as an extension of their office. A large number of procedures which could be done in the office are done in the Emergency Room, e.g., dressing changes, wart removal, immunization, etc.

2.1.12 Laboratory/Pathology

Pathology Services are provided contractually by a group of Pathologists at the Royal Columbian Hospital who visit several times a year. Histopathology is provided by the Terrace Hospital

Pathologist (but the Pathologist does not visit Prince Rupert). In the last year, with the addition of three major clinical specialists, the Laboratory has seen a large increase in activity (around 16%), which has put it under significant pressure.

2.1.13 Diagnostic Imaging

Radiology Services are provided by a full-time resident Radiologist who has special expertise in CT Scanning and Angiography. Prince Rupert's current capability includes General Fluoroscopy, Ultrasound, Mammography, and General Radiology. The hospital is currently looking at upgrading one of the rooms with new digital equipment and perhaps the capability for limited Angiography. All of the Nuclear Medicine tests are performed in Terrace and this service is considered to be satisfactory.

Technical expertise in the Department of Radiology is excellent for a hospital of this size and more than adequately copes with the range and scope of services provided.

2.1.14 Pharmacy

There has been a significant increase in utilization of the Pharmacy Department in the last year with the addition of the new specialists, particularly the Internal Medicine specialist. Drug utilization and prescribing practices have changed substantially and the budget has increased very significantly. Additionally, Prince Rupert is now providing Pharmacy Services to Kitimat and Nishga.

2.1.15 Medical Records

This Department was observed to be well-run, well-organized and timely in all aspects of its function, with a good understanding of the HMRI database by those at a senior level. Very adequate information is available. At this time, insufficient use is made of the Medical Records database by both management and Medical Staff.

2.1.16 Bio-Medical Services

Bio-Medical Services were established in February 1992. Prince Rupert shares this service with the Queen Charlottes. The work area is small, noisy, and dirty. There is currently no provision to lock tools away.

2.1.17 Food Services

The Review Team is appreciative of the fact that the Manager (who is on maternity leave) made herself available to meet with the Team. The Manager spends approximately 70 percent of her time on outpatient services and clinical inpatient work. The Manager's workload has increased due to the number of outpatients seen and the increased requirements for diet planning. The balance of her time is spent managing the food service operation. There did not appear to be any large issues within the Food Services Department. Productivity in the Department is close to the group average (.81 hours paid per weighted patient day vs. the Peer Group average of .77).

The current practice of soaking dishes is labour-intensive and an overhead spray in the dish room will soon be installed. Approval for a new steamer has also been granted.

2.1.18 Plant and Support Services

The Director of Plant and Support Services has been with Prince Rupert Regional Hospital for nine months. Responsibilities of this portfolio include Housekeeping, Dietaries, Plant, and Laundry.

Eight projects (planning for capital expenditures) are under way. Funding for a master development plan has been approved.

2.1.19 Housekeeping and Laundry

The Manager of Housekeeping and Laundry appears to be running a satisfactory service. There were no grievances outstanding. Both Housekeeping and Laundry equipment are adequate to good. The Laundry Service has potential to increase the number of pounds processed without the addition of any further equipment. Productivity within the Laundry Department could probably be improved to 60 lbs. per worked hour (as compared to the current 46 lbs. per worked hour). The hospital could potentially increase its laundry volume and revenues by submitting proposals to various agencies within the City of Prince Rupert to provide them with laundry service.

2.2 CURRENT SCOPE OF HOSPITAL-BASED SERVICES AND DEPARTMENTAL OPERATIONS: MILLS MEMORIAL HOSPITAL

Mills Memorial Hospital is operated as part of the Terrace Health Care Society. It is strategically situated at the intersection of Highway 16 and Highway 37. The Terrace Health Care Society also operates Terrace View Lodge, an 86-bed facility consisting of 65 long-term care and 20 extended care beds and one respite care bed. It is located about one mile from the hospital. The hospital provides all office support for this facility, including payroll, accounts payable and receivable, and some administrative functions. Remuneration for these services amounts to approximately $100,000 per year.

Mills Memorial Hospital has been the subject of several reviews over the past two years. Following these reviews and faced with budgetary reductions, it reduced its bed complement from a total of 89 to 67 beds comprised of 10 Psychiatric, three ICU, 30 Medical/Surgical, six Paediatric, and 18 Obstetrical and Gynaecological beds. Primary and secondary medical and surgical services are offered at Mills Memorial Hospital including Internal Medicine, General Surgery, Obstetrics and Gynaecology, Anaesthesia, Urology, Paediatrics, Otolaryngology, Psychiatry, General/Family Practice, Emergency Medicine, Diagnostic Radiology, and Pathology. Dental Surgery is also performed at the hospital. These services are augmented by visiting specialists in Ophthalmology, Dermatology, Rheumatology, Neurology, Psychiatry, Plastic Surgery, Orthopaedic Surgery, and Oncology.

The hospital also provides Nutrition Counselling, Diabetic Outpatient Services, Stress Testing, Physiotherapy, Laboratory and Diagnostic Imaging Outpatient Services, Pharmacy Services, Fetal Monitoring with Non-stress Testing, and Pastoral Care. Additionally, there is a Nuclear Medicine Department, Palliative Care, Prenatal Education, Psychiatric Outpatient Program, and Biomedical Engineering Services. An Orthotics Program is provided on a visiting basis.

2.2.1 Medical Staff

The Medical Staff of the hospital is comprised of the following: 12 General/Family Practitioners, a specialist staff of two General Surgeons, one Urologist, one Obstetrician and Gynaecologist, one Pathologist, one Radiologist, one Psychiatrist, two Anaesthetists, one Internist, one Paediatrician, and one Ear, Nose, and Throat specialist. Mills Memorial Hospital has been successful in the recruitment and retention of a significant diversity of Medical specialists over the years and, indeed, has the greatest concentration of Medical specialists north and west of Prince George and Kamloops. The hospital acts as a regional referral centre for part of the Northwest Region, mainly in a north/south line from Kitimat through to Stewart, including Hazelton. There is little referral eastward from Prince Rupert and the Queen Charlottes. There is reasonable collaboration with Kitimat to the south. The Urologist visits both Kitimat and Prince Rupert; Histopathology is provided to Prince Rupert by Mills Memorial's Pathology Department, and some Ear, Nose, and Throat work is performed for Prince Rupert at Mills Memorial.

2.2.2 Administration

The current administrative structure of Mills Memorial Hospital is built on the corporate model and the appropriateness of this for a hospital of this size and type is questioned. An organization the size of Terrace Health Care Society should evaluate the need for five directors. As discussed further in Section 4.1, opportunity exists to enhance the responsibilities of the Director of Finance and phase out one of the other Director positions. The Director of Resident Care could also be assigned additional responsibilities.

The lack of leadership in utilization and quality management and related issues was noted, as was the lack of use and knowledge of the HMRI data base as a management tool.

2.2.3 Nursing Services

Overall, the staffing levels and quality of nursing care are good, with the exception of the Emergency Department. During the night shift there is no nurse in the Emergency Department. The Nursing Supervisor fulfils a number of functions including being a resource person, assisting in deliveries, break relief, attending to visits in the Emergency Room, and answering the phone. This places the Night Supervisor under a significant amount of stress and risk, with a potential of having to be in several places at once.

The Nursing Supervisors are frequently utilized as clinical experts and are able to work comfortably in all areas of the hospital. They are used as Clinical Resource Nurses, 24 hours a day. The Daytime Nursing Services Co-ordinator is not utilized as a manpower resource as the Head Nurses fill this function. However, the Evening/Night Supervisors are considered essential. The Nursing Services Co-ordinator is utilized as a "clinical teacher" to new staff nurses when time permits.

There are few appropriate and realistic job descriptions for nursing positions at all levels. Uncertainty exists as to who is actually in charge and what their authority and responsibilities are.

Senior Nursing Administration appear to lack awareness of day-to-day activities. Head Nurses reported that there is very little direction or feedback given to them when they raise issues or concerns. This lack of direction is reported by staff to be the cause of low morale among the workers. Further, dispersal of human resource functions among different management personnel creates poor employee/employer relationships.

The lack of formal education programs creates serious concerns among the Nursing staff with regard to upgrading and maintaining critical care skills needed for the Intensive Care Unit. Education is left primarily to the Physicians or to the Nursing Services Co-ordinator whose job description would defy the abilities of most people. Transfer of functions were required in the ICU and Labour/Delivery areas, but there is no formal program in place to ensure certification.

Annual certifications are left to the individual to arrange with the appropriate Physician. Mills Memorial sponsors the ACLS course approximately twice a year with applicants being taken from all over the region. Priority is given to Mills Memorial staff. Even though Mills Memorial Hospital sponsors this course, not all ICU and Emergency staff have availed themselves of it. Many of the skills needed are learned on the job and through very occasional inservices.

Overtime due to call-back is substantial with the Physicians essentially initiating the call-back process, particularly for the Operating Room. Review of the appropriateness of off-hours surgical bookings is not currently being done and should be. There seems to be a lack of understanding at the Senior Management level with regard to what is a reasonable add-on/emergency-type surgery and what is not. This causes confusion and increased costs in the Nursing area.

Recruitment and retention of staff is not reported as a serious problem. All Nursing Units except the OR and ICU report adequate casual staff to cover sick relief and vacation. Recruitment difficulties have lessened somewhat with the establishment of the Nursing Program at the Northwest Community College in Terrace. Prior to this year the College only offered the first year of the Nursing Program, so students had to finish in Vancouver. Many did not continue due to the cost. The first complete two-year program will be graduating in July 1993 with approximately 18 nurses, which will help both Terrace and the rest of the region. Strong ties will need to be forged between Terrace, Prince Rupert, Kitimat, and the Regional College through Preceptorship Programs to ensure retention of these nurses.

2.2.4 Emergency Department

The Emergency Department is not staffed on a 24-hour basis but is covered by the Medical Staff on an on-call rotation. The Department consists of eight stretchers with three day-care surgical beds. The staffing pattern is unusual in that a Licensed Practical Nurse is scheduled to be alone from 0700-0800 hours, seven days a week. The hospital does not require or provide CPR training for the LPNs. Although small, the Department seems to be well-run and there is little complaint with regard to response time by Physicians. Complaints relate to the Department being used for procedures which could have been done in the doctor's office. During the visit by the Review Team, it was learned that a number of physician offices in the community are not wheelchair accessible. As a result, a number of visits to the hospital's Emergency Department are simply a matter of convenience for physician and patient. Other complaints relate to administrative decisions being made by administration, with departmental staff feeling that they have no input into the budget or with respect to reductions in service and supplies.

2.2.5 Operating Room

The Operating Room appears to be generally well-run but has significant problems with after hours add-ons. A review of two months of the surgical add-on list for January and July demonstrated that there are many procedures which are questionable as emergencies.

It is recommended that:

- **The Mills Memorial Hospital and Medical Staff develop a target wait list by surgical specialty. When the wait list falls below the target and the hospital begins to encounter operational inefficiencies, OR resources should be reduced or the OR time reassigned to other physicians for the next several months.**

The hospital has the responsibility to ensure its Operating Room resources are used in an efficient manner.

It is recommended that:

- **The Administration and Medical Staff at Mills Memorial Hospital discuss effective utilization of the Operating Rooms in an open manner and that the hospital develop an OR booking system that will meet mutual needs.**

2.2.6 Intensive Care Unit

This unit is funded for three beds but five can be used (including 2 Telemetry beds). The Internist felt that the set-up was reasonable. Outstanding concerns relate to the requirement for an extra funded bed and problems with the recruitment of casual staff. The Unit has two new ventilators acquired recently with the help of the Foundation. Permanent pacemaker installations are provided at Mills Memorial Hospital.

2.2.7 Nursing Units

The Medical/Surgical Nursing unit is well-organized and well-run. There did not seem to be a great deal of staffing flexibility as the occupancy levels on this unit are fairly high.

The Obstetrical and Gynaecological area, with 18 obstetric and gynaecologic beds, is not busy and has not undergone a reduction in beds following the previous reviews (as has the Paediatric and Psychiatric areas). A statistical review indicates that this area of the hospital provides significant opportunity to rationalize and balance the number of beds in relation to predicted utilization.

The Psychiatric Unit has reduced beds from 16 to 10 and a new Psychiatrist has recently arrived. It is difficult to evaluate this service at this point in time as the new Psychiatrist has not really had time to review the service delivery and match it to the needs of the area or, indeed, the region. This is the only hospital with a Psychiatrist on staff in the Northwest.

The Paediatric Service, which reduced beds from 22 to six, now incorporates some day-care surgery and is again not busy. It appears to be well-organized and well-run from a nursing standpoint.

It should be stressed that the closure of the 16 paediatric and six psychiatric beds at Terrace Health Care Society was, for the most part, a closure of beds that were not used. The closure of the beds was announced along with the budget cutbacks as a means to let the community know about the tight financial circumstances the Society finds itself in. The closure of beds did not need to coincide with the budget announcements. The community assumes the beds that were closed were being used.

2.2.8 Laboratory/Pathology

According to the Ministry of Health's 1991/92 hospital data the laboratory at the Mills Memorial Hospital is the most productive within the peer group (in terms of units per paid hour). The laboratory staff suggest that with the replacement of certain pieces of equipment their jobs could be made easier and more productive. Due to increasing workload pressures, laboratory staff are finding it difficult to maintain a positive attitude.

2.2.9 Diagnostic Imaging

There is a full-time Radiologist who performs General Radiology services with diagnostic ultrasound. The Radiology Department has three general rooms, one of which is a relatively new digital GE room with angiographic capability but where no angiograms are performed. The other two rooms are Picker equipped and appear to be relatively modern and suitable of the size and case mix of the hospital.

The most recent impact analysis regarding the provision of CT services at the Terrace Health Care Society does not indicate the capital cost of the equipment nor the related construction/renovation costs which may be incurred. Further consideration also needs to be given to the availability of medical and technologist manpower to support a CT service.

It is doubtful as to whether the Ministry of Health would approve the purchase of a CT scanner without knowing the cost of any associated renovations or new construction. It is also interesting to note the Director of Finance has not yet been involved in the development of this impact analysis even though the current draft document includes an assessment of fixed and variable operating costs.

2.2.10 Medical Records Department

The Department employs eight full-time and one part-time employee and operates from 0800-1600 hours, weekdays. There is no evening, night, or weekend coverage. Despite this, the turnaround time (about 24 hours) for inpatient work is commendable. Departmental complaints focused on the lack of holiday and sick time coverage with potential lead-up to a one-month backlog in non-urgent work. Relationships with the Physicians seem fairly good. The chart counts are certainly very reasonable. The main concern in the Department appears to be low morale, work demands, and lack of formal training when new systems are implemented. The HMRI database did not appear to be well understood. The work stations in the Medical Records Department are not well laid out and do not provide staff with appropriate work spaces. It is suggested that the hospital incorporate into its equipment planning process the development of appropriate work stations and equipment for Medical Records staff.

2.2.11 Housekeeping

Staff levels in Housekeeping were reduced as part of the recent budget initiatives. This is resulting in the remaining staff having increased workloads and decreased morale. Part of the rationale for the decrease in staffing levels was that less space would need to be cleaned due to bed closures. During the visit by the Review Team it was not clear that less space would, in fact, need to be cleaned. On the date of the visit, it appeared the entire inpatient Paediatric Unit was being used. Furthermore, eight outpatient beds have been opened on the Paediatric ward. It is suggested that routine workload assignments for Housekeeping staff be reviewed with input by the Housekeeping Supervisor and that every effort be made to not use those rooms on Paediatrics and Psychiatry which are intended to be vacant.

2.2.12 Food Services

At Mills Memorial Hospital the Chief Dietitian (and the only Dietitian on staff) has recently been reduced from full-time to half-time and is no longer responsible for managing and directing the Food Services operation at the hospital. The majority of the incumbent's time is currently spent providing dietary counselling.

It is recommended that:

- **Mills Memorial Hospital review the Food Services operation with particular emphasis on professional time required to support not only dietary counselling, but leadership and direction for the Department.**

2.3 CURRENT SCOPE OF HOSPITAL-BASED SERVICES AND DEPARTMENTAL OPERATIONS: KITIMAT GENERAL HOSPITAL

Kitimat General Hospital is a large facility which opened in March 1960 with a capacity of 216 beds designed to serve a population anticipated at that time to grow to around 50,000. Thirty-two years later the population remains in the 11,000-12,000 range. It is generally acknowledged that the current Kitimat General Hospital is oversized given current and projected service requirements. Further, the layout of the building will make it difficult to renovate in a cost-effective way.

In discussions with both the Ministry and the hospital, it appears there is consensus the current building should, at some point, be abandoned and a new facility built. The Ministry of Health and Kitimat General Hospital should continue to work in a collaborative fashion toward the development of a new facility.

Currently, the hospital operates 34 acute beds and 35 long-term care beds, which it administers in the same building. Twenty-nine of the latter are extended care and six are intermediate care. The current acute bed complement of 12 General Surgery/Orthopaedic beds (4 of which are used for day-care surgery), 11 Medical beds, five Maternity beds, four Paediatric beds, and two Special Care/ICU beds. Additionally, there are two Birthing beds. There are approximately 150 deliveries per year and, interestingly, multiple births and high risk pregnancies are transferred to Vancouver despite Paediatric and Obstetrical services available in Terrace. A few high risk deliveries are managed in Terrace but the majority of these types of patients are flown out.

In the past two years there has been a significant reduction in the number of beds set up and a rationalization of the use of space within the hospital. The previous 10-bed Maternity Unit has been moved to the second floor and now all of the acute medical services are housed on one floor for a total of 34 beds. Although not ideal from a Human Resources standpoint (particularly Nursing), this layout makes sense. Improvements could be made to the physical layout of the observation area by putting a bay-type window into the main Nursing station.

Kitimat General Hospital provides primary and secondary medical and surgical services to its community. Services provided by physicians who live locally include: General Surgery, Obstetrics, Anaesthesia, Orthopaedics, General/Family Practice, and Emergency Medicine. Outreach Programs in Obstetrics and Gynaecology, Urology, Paediatrics, Ear, Nose, and Throat, and other secondary Specialist Services are provided by a Visiting Specialist Program. Diagnostic Radiology and Pathology are provided at the hospital for inpatients and outpatients with Medical Directorship of these programs being provided from Terrace.

2.3.1 Medical Staff

The Medical Staff consists of 11 General/Family Practitioners with one General/Family Practitioner/Anaesthetist, one full-time specialist Anaesthetist (on the second year of a work permit), one General Surgeon, and one Orthopaedic specialist. The latter provides Orthopaedic services to Terrace, Hazelton, and Prince Rupert. The Internist from Terrace provides visiting Internal Medicine services; a Paediatrician from Terrace visits two days per week; a Radiologist visits weekly; a Pathologist visits one to one and a half days per week; a Urologist from Terrace visits weekly; and an Ear, Nose, and Throat specialist operates one day per week.

2.3.2 Administration

The hospital has four director positions reporting to the Executive Director. Bearing in mind that this is a small community hospital administering 34 acute beds and 35 long-term care beds with only one regional service in Orthopaedics, the administrative structure seems inappropriate. As discussed further in Section 4.1, a hospital of this size should be able to function effectively with three director positions - a Director of Patient Services, a Director of Finance Services, and a Director of Personnel Services. The various administrative and support departments could be aligned with either the Director of Personnel or the Director of Finance, depending on incumbent skills and background.

Administration is seriously hampered by the poor relations of the Board and Administration with the Medical Staff. These relationships do not seem to be improving over time despite good ideas and concepts brought forward by the relatively new CEO (appointed in 1990). There appears to be a major deficiency in the education process for Physicians with regard to hospital budgeting, bed and service utilization, and current trends in health care delivery. The Physician group have little or no understanding of quality management/utilization activities at Kitimat General Hospital, or the application of available data to these activities.

The poor relationship between Kitimat General Hospital Medical Staff and Administration appears to be the result of a number issues not being addressed or resolved in a satisfactory fashion. One underlying theme is the lack of communication between the two sides. Significant time needs to be spent on education for the Board, Medical Staff, and middle management group.

As outlined further in Section 4.5, it is suggested that joint conference meetings be held on a regular basis so that issues of common concern can be addressed in a satisfactory manner.

2.3.3 Nursing Services

Kitimat General Hospital also has a perceived lack of leadership skills in Senior Nursing management. The incumbent has been promoted through the ranks without being given the appropriate support and education required for the position.

The overtime situation at Kitimat is intolerable. It was reported time and again, both at the hospital and a public forum, that nurses are often expected to work 16-24 hour shifts, a surprise to nursing management. The majority of overtime reported can be attributed to the current practice of surgeons setting their own operating schedules. Surgeons also have the mandate to call in nursing staff on overtime to work in the Operating Rooms and general duty nurses are required to comply. These problems are contributing to the overall low morale found among nursing staff at the hospital.

Low morale is also associated with nurses having received little or no inservice education to adequately prepare them for the amalgamation of the Maternity and Medical/Surgical Units and the increase of orthopaedic activity resulting from the arrival of the Orthopaedic Surgeon.

The present incumbent in the Infection Control/Continuing Education Officer/Quality Assurance Co-ordinator position is considered and used as a clinical expert by most staff. She is frequently called in off hours as this position was cut back to half-time.

Job descriptions do not adequately reflect or describe the staff nurses' positions. There is a generic job description which does not identify each nurse's area of responsibility or the duties relevant to each position. The question of "Who is in charge?" is also a problem at Kitimat General.

Nursing supervisor positions were deleted in July 1992 and the previous responsibilities allocated to the in-charge nurse on the Medical/Surgical Unit and to the emergency/float nurse. At this time there was also a decrease from one full-time employee to 0.5 of a full-time employee in the Infection Control/Continuing Education Officer/Quality Assurance Co-ordinator position.

Casual staff, when and if available, have very little advanced skills as most are new graduates. In the past, Kitimat has been forced to rely on an outside nursing organization for skilled Operating Room nurses. Inservices are provided on an infrequent basis. The recruitment of casual staff remains a problem because applicants want regular hours which Kitimat is unable to offer.

2.3.4 Medical/Surgical Nursing Unit

This unit, with 12 General Surgery/Orthopaedic/Day-Care Surgical beds, 11 Medical beds, four Paediatric beds, and two Special Care/ICU beds, is staffed around the clock with what appears to be appropriate staffing levels. Further comments on this have been made in the Nursing section of the report. The ICU beds are not truly funded at this level of care, although some fairly high acuity patients are looked after. Fairly sophisticated monitoring and treatment facilities are available including ventilation/respirator equipment. The Paediatric beds appear to be under-utilized and again are staffed by personnel that look after the Medical, Surgical, Paediatric, and Maternity floor.

2.3.5 Maternity Unit

The hospital now has a four-bed unit located on the main nursing floor at the end of one wing. It appears to be quite functional with two reasonably well-equipped Birthing Rooms. There are approximately 150 deliveries a year, equivalent to one birth every 2.5 days. Consequently, the unit is not constantly staffed but Nursing Administration ensure that Maternity-trained nurses are always available on shift on that floor. Most of the deliveries performed at the hospital are low risk, as one would expect, and are carried out by the Family Physician group who also handle elective/emergency Caesarean sections, as does the General Surgeon.

2.3.6 Operating Rooms

The hospital has one Operating Room staffed five days per week from 0800-1400 hours. The OR frequently incurs overtime. In addition to the Orthopaedic Surgeon and the General Surgeon, several of the General/Family Practitioners utilize the OR. With the arrival of the Orthopaedic Surgeon there are increasing numbers of out-of-hours surgeries being done with associated costs. There is a small area used as a PAR. There is one full-time, non-Canadian certified Anaesthetist and a General/Family Practitioner Anaesthetist who works mornings only. CSR is adjacent to the OR and is supervised by the same Head Nurse.

On the two days the Review Team visited Kitimat General Hospital, the Operating Room had less than 10 cases for the two days combined.

Physicians do not appear to be forwarding the booking card and related documentation to the hospital at an appropriate time, and the hospital does not have an adequate booking system. The hospital appears to have only 65-68 patients on the Operating Room wait list at any given time.

It is recommended that:

- **The Kitimat General Hospital and Medical Staff develop a target wait list by surgical specialty. When the wait list falls below the target and the hospital begins to encounter operational inefficiencies, OR resources should be reduced or the OR time reassigned to other physicians for the next several months.**

The hospital has the responsibility to ensure its Operating Room resources are used in an efficient manner.

It is recommended that:

- **The Administration and Medical Staff at Kitimat General Hospital discuss effective utilization of the Operating Rooms in an open manner and that the hospital develop an OR booking system that will meet mutual needs.**

2.3.7 Emergency/Outpatient Department

There is an old, small, but functional area located on the ground floor at the rear of the hospital which is reasonably well-equipped and serves as the hospital's Emergency Department. Patients access this area through a small waiting room. There is a television monitoring system in place to view patients prior to their entry. The Emergency Department is not staffed but, when needed, personnel are pulled from the main nursing floor.

Admitting/Switchboard staff at Kitimat General Hospital are generally working alone on afternoon shift. The work station is set up in such a way that people coming through the Emergency Department are not heard or seen, creating an unsafe work environment. Presently, a TV monitoring system is in place. Perhaps an audible monitoring system is warranted so staff can see and hear people as they enter the Emergency Department.

There is an emergency on-call roster for physicians which is felt to function satisfactorily. There were few complaints regarding response time. Many of the physicians in the General/Family Practice group have taken additional training in the provision of emergency services (at least to the levels of ACLS and ATLS). The numbers of patients presenting to the Emergency Department on an average day is between 12 and 16. Most of these are seen between 0800-1600 hours. Usually only three or four patients are seen in the evenings and an average of less than one per night between 2400-0800 hours. Major motor vehicle accidents are unusual and there is relatively little major trauma.

2.3.8 Pharmacy

Pharmacy Services are supervised and run out of Prince Rupert, an arrangement which has been in place for about a year. There is no on-site Pharmacist and little evidence of drug monitoring, utilization, or pharmacy and therapeutics reviews.

2.3.9 Diagnostic Imaging

The Diagnostic Imaging Department operates between 0800-1600 hours with on-call coverage on weekends. The Department appears reasonably well-equipped for the type of coverage offered, although one would question the ability to respond to more sophisticated requests for procedures in Orthopaedics and Obstetrics/Gynaecology. Nuclear Medicine requirements in Orthopaedics are provided out of Terrace.

The productivity of the Radiology Department at Kitimat General Hospital is significantly less than that of the Peer Group. This could be affected by a number of variables including the amount of overtime and callback incurred. It is believed the productivity in the Department can be improved if only by reducing the amount of overtime and callbacks; therefore, the hospital should develop appropriate protocols to reduce the amount of overtime/callback being used. The hospital should also undertake a comparative analysis of the Radiology Department with its peer hospitals with the goal of improving productivity.

2.3.10 Laboratory Services

Laboratory Services were reviewed briefly. Most patients are seen between 0730-0900 hours or 1230-1430 hours. This laboratory provides a reasonable level of sophisticated tests and interpretation to the physicians and patients of the area. More complex tests are sent to the British Columbia Bio-Laboratories in Burnaby. There is also some linkage with Pathology Services in Terrace with the Pathologist visiting the hospital on a regular basis.

Hospital staff at Kitimat General Hospital advise that the laboratory is relatively well-equipped. The productivity ratio of 35 units per paid hour is below the Peer Group average of 39 units per paid hour (1991-92 fiscal year). There are likely a number of reasons which contribute to this difference. For example, it is more difficult for smaller labs to achieve economies of scale. The amount of overtime utilized can also affect the calculation. These issues should be further addressed by the hospital.

2.3.11 Physiotherapy

The productivity within the Physiotherapy Department at Kitimat General Hospital is significantly less than that for the Peer Group (1.08 attendances per paid hour as compared to the Peer Group average of 1.35 attendances per paid hour). Although the physical space is extremely poor resulting in poor work flow, it is difficult to explain the large variation from the Peer Group. Further, it appears there is little or no proper training provided to utilize new equipment (e.g., CPM machine). Consideration needs to be given to improving the space allocation for Physiotherapy services and to addressing productivity issues within the department.

2.3.12 Medical Records Department

This Department is located in very cramped quarters on the main floor. Work stations need to be upgraded to improve the work environment and staff productivity. The Department appears to be remarkably well-run considering the facilities and the cramped quarters. The manager of this department also supervises Admitting and Switchboard Services. The staff did not seem to have a good understanding of the requirements and information flow through HMRI. Lack of computerization in the Department is noticeable and should be addressed since it limits productivity.

2.3.13 Housekeeping and Linen Services

Housekeeping and Linen Services at Kitimat General Hospital appear to be efficiently run. The Review Team was advised that:

- The use of sick time is minimal;
- There have been no grievances for the past two years;
- WCB incidents are minimal; and
- Overtime is minimal.

Available equipment is considered to be adequate with the exception of some laundry equipment which should be included in the equipment priorities of the hospital.

2.3.14 Food Services

Kitimat General Hospital contracts with Versa Services for management of Food Services. The Department of Food Services has a number of quality assurance mechanisms in place and as a result appears to have good quality Food Services.

The Review Team notes, however, that HSA has an outstanding policy grievance at this hospital concerning the assignment of bargaining unit work to individuals outside the bargaining unit.

2.3.15 Materiel Management

There is a full-time Materiel Manager and two part-time positions within this Department. Various functional issues were reviewed and departmental workloads discussed.

It is suggested that the hospital undertake a review of the Materiel Management Service to ensure that it is organized and staffed appropriately.

2.3.16 Payroll System

At Kitimat General Hospital there appears to be some confusion regarding the operation of the Payroll System and related roles and responsibilities. In some departments (e.g., Nursing and Laboratory), it appears that each individual employee is responsible for filling out their own payroll cards (every two weeks). These cards are then signed off by the respective manager. This poses a problem when managerial staff (for whatever reason) are unavailable or absent from the hospital. In a hospital of this size, payroll card responsibilities would normally be assigned to a payroll clerk or similar position.

It is recommended that:

- **Kitimat General Hospital review the payroll card system and delegate responsibility for card completion to payroll personnel.**

2.4 UTILIZATION OF HOSPITAL SERVICES

Over the past few years acute care hospitals have increasingly recognized that they must become actively involved in effective utilization management to ensure that, in times of severe economic restraint, they are most effectively using the limited resources available to them. As part of their utilization management programs they have begun to monitor many activities within their hospitals, including the appropriateness of use of inpatient beds, the effectiveness of use of the operating rooms, and the validity of use of diagnostic services.

The Ministry of Health has also recognized the significance of effective utilization management, as evidenced by their statements in the 1992/93 funding letter to hospitals:

> "Utilization management is one of the most effective strategies that a hospital can develop to provide the proper balance between continued service demand and limited resources while at the same time ensuring that quality care is given. It is expected all facilities will have in place an effective, hospital-wide program and a report detailing the initiatives taken to date."

2.4.1. Current Utilization Patterns

Throughout the review the team noted significant problems in each of the hospitals relating to effective utilization of their programs and resources. While there were individual instances of utilization reviews and attempts at discharge planning, none of the hospitals had an overall program developed for utilization management. As a result, beds and other services were not being used effectively and resources were being inappropriately utilized.

The medical staff at the hospitals appeared to have very little involvement in utilization reviews and, in some instances, did not appear to be interested in the topic. Very little effort was being made by the physicians to control the use of hospital resources and to make certain that patients were being discharged as quickly as possible.

Patient Days: One basic indicator of inpatient utilization is the number of patient days utilized per 1,000 population (adjusted for the relative age distribution of the population in the catchment area). As noted in Section 1 of this report, the Local Health Areas in Prince Rupert, Terrace and Kitimat all have utilization rates which are significantly higher than the provincial average of 970 patients days per 1,000 population:

Local Health Area	Patient Days per Thousand Population	% Utilization Over the Provincial Average
Prince Rupert	1750	80.4%
Terrace	1770	83.2%
Kitimat	2388	146.2%

Note: Prince Rupert's rate has been adjusted from 1920 to reflect 3 long term care patients improperly included in the original data.

These figures are based on the 1990-91 age standardized utilization rates using 1990 population figures. There has not been any substantial change in population or demographics in any of these areas since that time. The figures include acute and rehab services and exclude newborns.

The population profiles of the areas served by the three hospitals are fairly similar except that Prince Rupert has a substantially higher native population than the other two centres (17%). The population profiles are quite different from those found in most of the rest of British Columbia. The population in the Northwest region is relatively young with 6 percent or less in the over 65 age group. Hospital utilization by this age group is known to be highest. Higher utilization, however, could be explained, to some extent, by patients from more remote areas of the catchment area requiring extended hospitalization, at a lower threshold, because they are unable to return home. Extended lengths of stay may occur where patients require further observation (which would occur on an outpatient basis if they lived closer to the hospital) or where there are deficiencies in community follow-up services. Nevertheless, it must be stated that the vast majority of patients seen at all three hospitals, Prince Rupert, Terrace and Kitimat, come from the local area, so the skew factor is not large.

The regional population of 63,400 (1992) is essentially concentrated in three major centres; Prince Rupert, Terrace and Kitimat, including 5,000-6,000 in the Queen Charlottes and other smaller communities scattered across a vast geographical area. It is the latter people, a fairly large number of whom are natives, that could skew utilization rates for the reasons outlined above. They represent between 7-9 percent of the total area population, so even if their patient days per thousand were twice that of the more accessible population (and one allowed a skew factor of around 10%) a utilization rate of 1,200 patient days per thousand population should be comfortably and realistically attainable.

Operating Room Utilization: Effective utilization of the operating rooms is another significant component of an overall utilization program. Again, the team had considerable concerns in all three hospitals about operating room utilization and its impact on staffing, use of overtime, etc. The operating rooms were not being scheduled to maximize effective utilization but frequently were being scheduled at the convenience of the physicians, resulting in callbacks and overtime. In addition, cases were still being treated on an inpatient basis that are now routinely handled through daycare surgery in other hospitals.

Overtime/Callbacks: Since wages and benefits represent approximately 80% of a hospital's annual operating cost, it is absolutely essential that hospitals ensure that staff are being used as effectively as possible. Invariably this means minimizing overtime and callbacks, through proper scheduling and monitoring of program activities.

Throughout this report the Review Team has identified a number of areas where staff are being inappropriately used, resulting in additional costs in both overtime and callbacks. It is essential that steps be taken as recommended in this report to reduce these costs and to provide a less stressful atmosphere for the staff.

Intensity of Care: The severity of the types of cases treated in a hospital can impact overall utilization, average length of stay, etc. Resource Intensity Weights (RIWs) have been developed to provide a basic indication of the acuity of care for all inpatient cases and the subsequent relative allocation of resources which would be required to treat the patient. Higher RIWs for various case groups would indicate the need for greater utilization of a facility. An analysis of the RIWs for the largest case groups in Prince Rupert, Terrace and Kitimat indicates that while Prince Rupert has proportionately higher RIWs than either Terrace or Kitimat, all of them are lower than other comparable hospitals in the province. This would indicate that there is no need for special consideration of utilization issues or related funding based upon levels of inpatient acuity.

It is interesting to note that the resource intensity weighting at Kitimat General has risen recently, probably because of the impact of the new Orthopaedic Surgeon. The RIW analyses also indicate the specialist complement at Terrace would tend toward the lower end of resource consumption per case by virtue of the specialties situated there.

2.4.2. Discharge Planning

Each of the hospitals could benefit greatly by introducing or improving discharge planning programs. These programs would serve the needs of patients and greatly improve communication with community-based health services.

Prince Rupert

The Prince Rupert Regional Hospital has a discharge planning process in place. The team attempts to meet weekly and includes three head nurses, the hospital occupational therapist, an occupational therapist from the Skeena Health Unit, a community health nurse, the counselling psychologist from the hospital's Psychiatric Day Unit, a home care nurse and an assessor from both Long Term Care and Acropolis Manor. Team members should place a higher priority on meeting regularly. No physician attends these meetings, but the physicians have input through the head nurse(s). The hospital does not employ a social worker to co-ordinate the planning and/or monitor appropriate resource utilization.

While it is encouraging to see that the parties have recognized the value of including representatives with knowledge of the hospital and the community, this team is comprised of too many people. A social worker typically serves on a discharge planning team. The Social Worker has the responsibility to assess the inpatients' needs prior to discharge and uses her knowledge of community-based services to liaise with the appropriate agencies. The Social Worker creates a working relationship with agencies that encourage continuity of care. Having a Social Worker on the team would facilitate and expedite safe, timely discharge of patients. It would also justify a decrease in the number of people on the team.

Meetings were originally held on an ad hoc basis to address the issue of Long Term Care (LTC) patients occupying acute care beds. The current team structure has been operational since early 1992. Although Team members describe the process as basically effective, and meeting the needs of the patients, the process would be improved if the hospital had earlier knowledge of pending admissions, such as having Public Health staff identify children at risk, or Mental Health staff identify clients destined for hospitalization. Further, the Medical Services Branch (MSB) Nurse, Mental Health Worker, and Public Health Nurse suggest that patients within their jurisdictions, would be better served if the hospital routinely notified them of details concerning pending discharges.

It is recommended that:

- **The Prince Rupert Regional Hospital hire one FTE Social Worker to co-ordinate the continuity of patient care prior to, and following, hospital admission.**

Terrace

Mills Memorial Hospital has a formal discharge planning process in place for its Psychiatric Unit and an ad hoc process in place for all other units.

The Psychiatric Unit begins its discharge planning before, or at the time of admission. The team consists of hospital and Mental Health staff, who, where indicated, may consult with the patient's General/Family Practitioner, religious leader and family members. Until her recent layoff, the team was reportedly well-served by the hospital Social Worker, and benefitted from her knowledge of the inpatients' needs and her role as a community services liaison.

The other units in the hospital are served by a discharge planning program that meets weekly and is comprised of a hospital nurse, a home care nurse, Long-Term Care assessor, and a hospital physiotherapist. Until her recent layoff, the hospital Social Worker also served on this team as community liaison and co-ordinator of the discharge planning process. Given the ad hoc nature of the discharge process, and the absence of a co-ordinator, the Review Team concluded that discharge planning needs to become more structured so as to ensure a smooth continuum of care for the patient upon discharge into the community.

It is recommended that:

- **The Mills Memorial Hospital hire one FTE Social Worker to ensure timely and effective discharge planning.**

Kitimat

Kitimat General Hospital does not have a formal discharge planning process in place. Home Care Nurses have actively communicated their interest as participants on a team. The hospital does not employ a Social Worker, but, given the number of beds at this facility, this is not unusual.

Because of inadequate discharge planning, patients not infrequently spend too much time in hospital or are discharged inappropriately or without community follow-up support. A formal discharge planning team would facilitate better linkages with community-based agencies.

It is recommended that:

- **The Kitimat General Hospital administration and key community-based agencies establish a hospital-based discharge planning process.**

2.4.3 Summary

In summary, there is a definite need for the Board, Administration, and Medical Staff of each hospital to work co-operatively in developing a joint pro-active approach to improving utilization and to introducing guidelines, standards and policies which would support such endeavours.

Traditionally, the hospitals in the Northwest have had proportionally greater availability of acute care beds than most hospitals in the province. Moreover, they have not had to undertake the same utilization and constraint programs that other hospitals in the province have. These hospitals are still relatively well-funded per capita in comparison with most hospitals, and have significantly more beds set up in relation to their populations than most other hospitals. Bed reductions are possible in all three hospitals if the levels of acute care bed utilization becomes more appropriate. This does not equate to a reduction in services; indeed, most facilities, when they have undertaken such exercises, have found that they have been able to balance their budgets and have re-allocated monies for programs and services which they could provide on an outpatient basis.

Mills Memorial Hospital and Kitimat General Hospital responded to the projected deficits following receipt of the 1992-93 funding letter by either laying off staff or predicting staff layoffs. These decisions could be revisited given the Review Team's findings of deficiencies in utilization management and costly, excessive use of overtime and callbacks. Once effective utilization management programs are in place, considerable cost savings could be realized, possibly negating the necessity for recent layoffs.

It is recommended that:

- **Mills Memorial and Kitimat General Hospitals revisit their decisions to lay off staff in light of opportunities for improved utilization management and related savings and in the broader context of the full range of recommendations arising out of this review.**

Control of hospital bed utilization is primarily influenced by the Physician group who make the decision to admit, continue the stay of, and discharge patients. Responsibility for good utilization lies not only with the Physician group, but also with Administration and the Boards, and it is imperative that educational programs and comprehensive utilization programs are started in the Northwest immediately in order to reduce the levels of utilization of acute care beds to more acceptable levels.

Criteria, programs, education packages, and human resources are available to these hospitals with regard to the implementation of these programs. The hospitals should take advantage of the wealth of information available within the province with respect to utilization/quality management programs.

Recognizing that there are specific utilization activities occurring in each of the hospitals, and yet noting the need for the development of more formal programs in accordance with the Ministry directives, **it is recommended that:**

- **Each hospital Board establish, as a priority, policies for the development of a utilization management program, and each hospital Administration and Medical Staff use these policies to develop comprehensive utilization management programs.**

- **Each hospital Board take an active role in monitoring the effective implementation and evaluation of the impact of such a program on resource consumption.**

Medical staff will have to be actively involved in all utilization management activities and will have to exhibit leadership in many aspects of the programs. It is suggested that each of the hospitals and medical staffs should target to reduce their inpatient utilization of beds to no more than 1,200 patients days per 1,000 population. While this target is still substantially over the provincial average of 970 patient days, it is considered to be reasonable as a short term target taking into consideration some of the geographical factors which impact overall utilization in the Northwest.

3.0 REGIONAL SPECIALIST SERVICES

This section presents the current and proposed profile of Specialist Services for the Northwest region. It discusses the Ministry of Health Guidelines relating to physician/population ratios. A number of factors are identified for consideration with respect to changes in the provision of Specialist Services.

The Northwest Region of British Columbia, as defined in the earlier part of this report, presents a significant challenge in delivering the best possible combination of Specialist Services. The uniqueness of the region exists mainly in its isolation from larger centres. There is a relatively large population living in reasonable proximity to each other, but they are isolated from the larger urban centres by several hundred kilometres. Air travel to the larger urban centres, which offer a full range of secondary and tertiary care, is expensive, and road and ferry travel is difficult. The proximity of the communities to each other is not substantially different from other areas in British Columbia (except for the more isolated rural areas where plane rides and boat trips of several hours duration may be required to bring a small number of that region's population to even primary medical care). Wintertime in British Columbia, because of the mountainous nature of the province, poses significant difficulties in travel to many residents including the Northwest, the east and west Kootenays, Okanagan, Cariboo and Peace River Districts. It is therefore important to ensure that as much of the required health care as possible is delivered in the larger local centres. This will minimize the need for more complex transportation to the bigger urban hospitals.

An overview of the above situation in and of itself suggests the requirement for developing regional services. Through regional co-operation and planning the objective of as much health care as possible being provided close to home is a realistic goal. During the visits to the three major communities it became clear that although some regional services are being delivered, each community tends to go its own way rather than truly co-operate. Regional planning initiatives up until now have not been successful, unless they led to the development of more services in that particular community. This parochialism pervaded the public meetings in all three areas and was also evident in the comments of staff of the three hospitals, particularly the Medical Staff (e.g., the concept of centres of excellence or centres of achievement is felt to be fine as long as those centres are placed in our own community). In order to achieve regional rationalization of services and provide the maximum amount of health care to the people of the Northwest, these attitudes have to be replaced by a broader perspective and appreciation of the needs of the whole Northwest, not just the local community.

Reviewing the historical development of the three major centres, it is not surprising that parochialism and self-centredness developed to the extent it has. The economic base of the three communities is quite different, and apart from liaisons between Kitimat and Terrace, there has not been a great need to communicate on regional issues in order for each community to sustain itself. Thus the concept of regional co-operation is not prevalent throughout the Northwest and indeed regional "competition" rather than "co-operation" seems to be the order of the day. In Terrace, for example, we heard how it was viewed as a victory that CN and another major employer had moved their Head Offices to that city from Prince Rupert. That attitude with respect to growth was particularly evident between Prince Rupert and Terrace.

If there can be a shift in parochial attitudes, then there is no reason why first rate primary and secondary medical services cannot be provided on a regional basis to the people of the Northwest, enhancing and expanding the already high quality of services currently being delivered there. This should also be achievable within the existing funding allocation level of resources.

There is no doubt that each of the three larger communities in the Northwest, with their attendant catchment populations, require a blend of acute care medical services to respond in a timely and appropriate fashion to their acute care needs. Primary care is provided by a group of very competent and well-motivated General/Family Practice physicians who also provide some secondary level services, i.e., General Surgery and Anaesthesia, in Prince Rupert and Kitimat. Secondary level services are provided by a combination of specialists living in the communities and a Visiting Specialist Program by specialists from larger centres mainly on the Lower Mainland and Victoria.

The ability of a community to recruit, retain, and sustain a given service is dependent on a variety of factors, not the least of which is appropriate population and demographics to provide a sufficient volume of cases to sustain that service. Predictions can be made with regard to service demands and volumes for a given Specialty for a particular population base and these would dictate appropriateness of the scope of services offered. It can be said that all people in British Columbia require access to these acute medical services, particularly Emergency Services, in a reasonably timely manner. All communities require a "core" of programs and services which it is able to sustain according to its population base.

Each of the three communities require acute care services and acute care beds to provide their services. Much of the service is being provided by primary care physicians with "core" secondary services in General Surgery, Internal Medicine, and Obstetrics and Gynaecology being available reasonably quickly when needed. Broadening the horizon from the community and the immediate referral base of each hospital to looking at the region as a whole, reveals a much larger population which itself would be able to sustain secondary level Specialist Services (which are not already being provided by the primary care physicians or secondary level specialists in the region). This larger population base allows the development of a rational specialist program for the region, provided the various communities in the region are prepared to get together to organize services on a truly regional basis.

Each community has developed an excellent base of core Medical and Specialist Services to provide care to its own community and immediate referral area. Terrace has developed secondary specialist programs further than either of the other two hospitals, with some of its specialists offering true regional services. The appropriateness and sustainability of the Orthopaedic Service in Kitimat will be dealt with elsewhere in this report. The current scope of Internal Medicine Services at Prince Rupert is dealt with in the Prince Rupert Regional Hospital Peer Review Report.

The current scope of services offered by the hospitals in the region, with exceptions noted here and elsewhere, is currently entirely appropriate for the populations served. Indeed, some services could be expanded, as described elsewhere in this report, to provide more services at a regional level by regionally based specialists. This would not preclude the necessity for visiting specialists in those specialty areas where a service would not be locally sustainable.

It is recognized that the recruitment of Canadian-trained specialists is difficult in more remote communities. Several specialists in the Northwest Region have been recruited from overseas and have been given special licence from the B.C. College of Physicians and Surgeons to practise in these northern communities.

3.1 CURRENT PROFILE OF SPECIALIST SERVICES

The region currently has a substantial number of Medical specialists divided among the three hospitals along with strong General/Family Practice backup. Table 5 below describes the current situation.

Table 5

DISTRIBUTION OF SPECIALISTS AND GENERAL/FAMILY PRACTITIONERS IN THE COMMUNITIES OF PRINCE RUPERT, TERRACE, AND KITIMAT

	PRINCE RUPERT	TERRACE	KITIMAT	TOTALS
General Practice:				
General/Family Practitioners	10	12	8	30
G.P. Surgeons	1	0	0	1
G.P. Anaesthetists	6	0	1	7
Total General/Family Practitioners	**17**	**12**	**9**	**38**
Specialists:				
General Surgeon	1	2	1	4
Internists	1	1	0	2
Orthopods	0	0	1	1
Anaesthetists	0	2	1	3
Otolaryngologists	0	1	0	1
Psychiatrists	0	1	0	1
Paediatrician	0	1	0	1
Urologists	0	1	0	1
Radiologists	1	1	0	2
Pathologists	0	1	0	1
Obstetrician/Gynaecologist	1 (as of Jan./93)	1	0	2
Total Specialists	**4**	**12**	**3**	**19**

The availability, or lack thereof, of ready accessibility to Specialist Services is a major concern to each of the communities. As noted in the introductory section, the referral rate from the hospitals in the Northwest to the major teaching institutions in the Lower Mainland (and to specialists operating in these institutions) is approximately 40-50 percent higher than from other outlying areas throughout the rest of the province. This is in part due to several factors:

- the non-availability of a larger non-teaching hospital closer to or more readily accessible to the Northwest;
- the lack of true regional utilization of the existing specialists available in the region;
- the lack of certain specialists in the Northwest; and
- a reported perception that Lower Mainland teaching hospitals provide a superior service to that available within the Region.

The recruitment and retention of specialists in any given area is dependent upon the ability of the population base to sustain that specialist. Sustaining factors typically relate to the volume and variety of cases which result in a challenging practice. Other factors include monetary reward and adequate relief and vacation time. The latter is important as the attrition rate can be very high when someone is on call seven days a week, 24 hours a day (even though the number of out-of-hours calls may not be high).

3.2 PROPOSED PROFILE OF SPECIALIST SERVICES FOR THE NORTHWEST REGION

Standard Ministry of Health Guidelines have been published in the past for various areas of the province for the appropriate ratio of specialist to catchment population. Using these criteria and trying to match them to the population demographics of the Northwest, the following table, (Table 6) suggests appropriate "specialist/population" ratios for this region. Additionally, using a population base of approximately 65,000, it is possible to identify the number of specialists which could theoretically be sustainable based on those population ratios. Identified also in the Table is the actual number of specialists currently practising in the region. It must be noted that these recommendations for levels of specialty services have taken into consideration the fact that there are existing visiting specialty programs which will provide backup support throughout the region. However, it should also be noted that if the suggested specialist complement were achieved, then the number of visiting specialists required by the region would be less, given the existence of planned regional co-operation.

Table 6

APPROPRIATE SPECIALIST/POPULATION RATIOS FOR THE NORTHWEST REGION[1]

SPECIALTIES	RATIOS	TOTAL NUMBER THEORETICALLY SUSTAINABLE	ACTUAL IN REGION	ADDITIONAL SPECIALISTS REQUIRED	COMMENTS
General Surgery	1:16,000	4	4	1	See 3.2.2
Plastic Surgery	1:100,000	0	0	0	
Neurosurgery	1:200,000	0	0	0	
Ophthalmology	1:32,000	2	0	2	
Orthopaedic Surgery	1:37,500	1+	1	0	With backup from visiting specialists.
Ear, Nose & Throat Surgery	1:50,000	1+	1	0	With backup from visiting specialists.
Urology	1:60,000	1	1	0	
Anaesthesia	1:16,000	4	3+ general/ family practice anaesthetists.	1	
Radiology (full service including CT)	1:20,000	3	2	1	3 with CT scanner in region.
Laboratory Medicine	1:30,000	2	1	1	
Geriatrics	1:300,000	0	0	0	
Rehabilitation Medicine	1:160,000	0	0	0	
Cardiology/Intensivist	1:68,000	1	Service provided by internists.	0	Service provided by internists.
Internal Medicine (including Cardiologist/ Intensivist)	1:12,0000	5	2	2	Reduced from a theoretical additional requirement of 3 due to relatively young age of population.
Neurology	1:85,000	0	0	0	
Obstetrics/Gynaecology	1:23,500	2+	2	0	see Sec 3.2.8
Paediatrics (General)	1:30,000	2	1	1	
Psychiatry	1:25,000	2	1	1	With backup from visiting specialist.

NOTE: 1. Requirements based upon catchment population of approximately 65,000.
Source: Ministry of Health Guidelines

The above specialist mix would add additional specialists in General Medicine (2), Paediatrics (1), Ophthalmology (2), Anaesthesia (1), Radiology (1), Laboratory (1), and Psychiatry (1) to the existing complement of specialists in the Northwest. In order to achieve the recruitment and retention of these specialists with adequate relief, vacation and off-call time, it would be reasonable to site them where the maximum community as well as regional benefit could be offered with opportunities to relieve each other. Additionally, there must be a comprehensive provincial plan for adequate relief and vacation time for specialists in one or two person situations in the more remote areas of the province.

In order to achieve all these objectives, the future roles and relationships of the major hospitals in the Northwest have to be resolved. Total regional co-operation is required to maintain service minimums for specific communities and access to the secondary services.

The concept of centres of excellence (where there is sufficient critical mass) should be pursued with enthusiasm and commitment. No one hospital in the region could or should provide all of the secondary services required by the Northwest community. Additionally, Outreach Programs from the major centres might be considered where it makes sense to bring the resource (i.e., the specialist) to the people rather than moving the people to the resource. The Review Team anticipate this would occur by having one or two day clinics for non-acute cases in appropriate areas where there was a sufficient population base to justify this. It is recognized that travelling conditions in the Northwest can be difficult in the winter. However, specialists who have regional programs ongoing at this time report that the number of occasions on which travel has been impossible or overtly dangerous, are relatively few.

In order for a hospital to sustain Specialist Services, it must also have an adequate population base from which to draw appropriate skill sets, especially within the Nursing profession. Additionally, management of the hospital must be flexible and responsive to the needs of the staff. In communities where casual staff are not readily available, staffing rotations for professional staff will need to be closely monitored to avoid burnout.

3.2.1 Overall Regional Strategy

It is imperative that an overall regional strategy for Specialist Services be developed using the Ministry of Health Guidelines (outlined previously), taking into consideration various other pertinent factors. These factors include:

- Adequate relief support to the specialist (either through additional specialists in the area, visiting specialists, or GP support) to permit sufficient time off and minimize burnout.
- Development of a Medical Manpower Plan with specification of the future roles and relationships of the hospitals in the Northwest (with the understanding that no one hospital in the region could or should provide all of the secondary services required by the population of the Northwest).
- Support for the use of Outreach Programs from the three subject hospitals whenever it is more appropriate to bring the specialist to the area rather than move the people to the specialist.
- Recognition that the Emergency Response Program and its use of ground and air transportation must be developed to ensure timely and adequate support.
- Identification of the ability of each hospital to sustain specialty services through adequate levels of well-trained professional and support staff. (Adequate and appropriate nursing support is a significant requirement.)
- Assessment of the ability of each hospital to utilize its resources to the greatest degree of flexibility to ensure maximum utilization of professional staff.
- Identification of the diagnostic and communication capabilities of each hospital.
- The current availability of Specialist Services in the Northwest.

As identified in Section 1.3, the catchment populations for the three hospitals range from approximately 12,000 for Kitimat to 25,000 for Prince Rupert (including the Queen Charlottes) and 27,000 for Terrace.

In assessing the ability of each of the communities in the Northwest to properly support specialty services, the Review Team recognized Kitimat, with a smaller population, would have difficulty in maintaining a sufficient infrastructure to support a sophisticated secondary service. The Team also recognized the importance of maintaining acute care beds and services in a community the size of Kitimat. It acknowledged that a community of that size with a limited natural catchment area would have difficulty sustaining a sophisticated secondary service such as Orthopaedics. Either of the other two major hospitals in the region, Terrace or Prince Rupert, could support the Orthopaedic service. The Team further recognized that Terrace is geographically more central to a larger percentage of the population of the region than Prince Rupert. It is also acknowledged that Prince Rupert has a substantial catchment area of approximately 25,000 and that it does have the advantage of an airport that is rarely closed due to adverse weather conditions.

In summary, recommendations for specialty placement outlined in the following sections take into consideration:

- Terrace is geographically more central to more of the population of the region (39,000 vs. 25,000) than Prince Rupert.

- Prince Rupert has a substantial catchment area of 25,000.

- Prince Rupert has a strategic location on the Northwest coast with an airport that is rarely closed due to adverse weather conditions.

- It is necessary to maintain acute care beds and services appropriate for the community at Kitimat General Hospital.

- It is necessary to maintain Operating Room capability at Kitimat General Hospital to serve the incumbent General Surgeon and Family Practitioners.

- It is necessary to develop a comprehensive Specialist Outreach Program for specialists visiting Kitimat General Hospital to provide appropriate specialist clinics and operative interventions for the Kitimat community.

3.2.2 Specialty Services

Outlined below is a description of recommended changes to Specialist Services in the Northwest Region. Each service is discussed in turn.

3.2.3 General Surgery

There are currently four General Surgeons working in the Northwest, one in Kitimat, two in Terrace, and one in Prince Rupert. The ratio of one General Surgeon to 16,000 population assumes specialist backup in clinical areas where there may be crossover. Traditionally there has been crossover with other surgical specialties and occasionally Internal Medicine, e.g., Endoscopy. This service population may, therefore, be somewhat high for a region where this type of crossover occurs. In Prince Rupert in particular, the General Surgeon felt under significant pressure with little time off or relief. This individual is serving a potential population of 25,000 with some backup from the General Practitioner Surgeon. Procedures, such as carpal tunnel syndrome procedures, which in other regions might be done by other specialists (such as an Orthopaedic specialist) are frequently performed by General Surgeons.

It is recommended that:

- **An analysis be performed of the demand, case mix, and workload of the current General Surgeon at Prince Rupert and that a further General Surgeon be recruited for Prince Rupert, should sufficient demand exist.**
- **Outreach Programs be developed in this and other specialties to service Prince Rupert and the Queen Charlotte Islands.**

3.2.4 Orthopaedic Services

There is currently only one Orthopaedic Surgeon working in the Northwest and this service is being offered at Kitimat General Hospital. The size and infrastructure available at Kitimat makes it difficult to offer a full Orthopaedic Service from that hospital and the Team felt that this service would best be provided from one of the other centres. Orthopaedics is a specialty which can involve both secondary and tertiary level services, particularly in the trauma field, and requires both an appropriate Medical and Nursing/Support Services infrastructure to enable it to offer its full potential. Prince Rupert Regional Hospital has both the Medical and Nursing/Support Services infrastructures (including Intensive Care) that will allow the service to be more fully developed (short of providing small joint replacement and complex spinal surgery) and also has the capacity, both on the Intensivist side of the hospital and the Surgical word, to absorb this service. Furthermore, there is better access to Prince Rupert (e.g., via Medivacs) on an ongoing basis for major trauma cases.

It is recommended that:

- **The Orthopaedic Service be transferred from Kitimat to Prince Rupert, recognizing that Prince Rupert Regional Hospital will have sufficient surgical bed capacity to absorb this service if the recommendations in the Peer Review Report are followed.**

- **Adequate funding be transferred to Prince Rupert Regional Hospital to inaugurate support and maintain a full Orthopaedic Service for the region. Funding should include allocations appropriate for major joint replacements and uncomplicated spinal surgery. Small joint replacements and more complex spinal surgery should be referred out to a tertiary centre.**

- **The bed requirements at Kitimat General Hospital be reviewed in conjunction with the transfer of the Orthopaedic Service and that a target of age/sex adjusted bed ratio of 2.75 beds per thousand population (which would equate to 24-26 beds for the immediate population) be established.**

3.2.5 Ophthalmology Services

Traditionally, Ophthalmology Services have been provided in the region at Hazelton, one of the much smaller hospitals in the area. This would necessarily limit the amount and type of Ophthalmological Surgery that could be provided. The major cost impact on an institution with an Ophthalmology Service is in lens implants and the attendant Operating Room time. Nowadays, a vast majority of these are done under local anaesthetic and can be provided in an ambulatory care setting. Other types of Ophthalmology Surgery would be relatively infrequent. The total impact of an Ophthalmologist on an institution (apart from the lenses previously mentioned) would not necessarily be high as retinal surgery and very complex eye procedures would tend to be referred out to a tertiary centre.

The types of secondary service already provided at Terrace are consistent with the provision of Ophthalmology Services there.

It is therefore recommended that

- **Ophthalmology Services be developed at Terrace to include cataract and external ocular procedures but not including a retinal service.**

3.2.6 Anaesthetic Services

Anaesthetic Services in the region are provided by the following:

- A full-time, certified Anaesthetist and a General/Family Practitioner Anaesthetist in Kitimat;
- Two full-time certified Anaesthetists in Terrace; and
- Six General/Family Practitioner Anaesthetists in Prince Rupert.

The services provided in Kitimat and Terrace would probably be adequate even with the changed specialist mix being recommended. The Orthopaedic Service switching to Prince Rupert would justify the acquisition of a full-time specialty trained Anaesthetist there who could also supplement the Intensivist Services offered there. This would allow better on-call/relief time for that service. The acquisition of a certified Anaesthetist for Prince Rupert would have some impact on the General/Family Practitioner Anaesthetists providing services there. This situation would need to be negotiated and resolved with the existing staff.

It is therefore recommended that:

- **Consideration be given to the acquisition of a specialist in Anaesthesia to support the Orthopaedic and Intensivist Services in Prince Rupert.**

3.2.7 Ear, Nose and Throat Services

Currently an Ear, Nose and Throat specialist operates from Terrace with an Outreach Program to Kitimat. Population data suggests that the region could support approximately 1.3 Ear, Nose and Throat specialists. This is an area where two could certainly not be justified but where the Outreach Program could be expanded to include Prince Rupert. Deficiencies in the service could be accommodated by visiting specialists from the lower mainland.

It is therefore recommended that:

- **The Ear, Nose and Throat specialist from Terrace be encouraged to develop a service to Prince Rupert.**

3.2.8 Urology Services

Review of the population base and age/sex profile suggests this region is able to support the services of one Urologist. This service is presently offered from Terrace. The Urologist has developed an excellent Outreach Program to the region and is commended on offering a truly regional service for this program.

It is recommended that:

- **The already excellent Urological Outreach Program from Terrace to Prince Rupert and Kitimat be maintained but that consideration be given to performing more surgical services in Prince Rupert.**

3.2.9 Gynaecology and Obstetrics

This service is currently being provided by a blend of the Family Practice group and the specialist Obstetrician and Gynaecologist in Terrace who will be complemented by an Obstetrician and Gynaecologist from Prince Rupert in January of 1993.

The young catchment population for the Northwest could possibly sustain 2.5 Obstetricians/Gynaecologists but a substantial portion of the obstetrical workload is already performed by the Family Practice group. Thus an additional Obstetrician/Gynaecologist would not be justified at this time. However as the region grows and if higher level Neonatology services are developed in Terrace the need for another Obstetrician/Gynaecologist in the region should be reviewed again.

3.2.10 Paediatric Services

The population of the Northwest is relatively young with a high native population who place significant demands on Paediatric services. Analysis of utilization data suggests there are major deficiencies in the provision of specialist Paediatric Services, particulary to the native population, and particulary with regard to diagnoses such as fetal alcohol syndrome. Moreover, a large number of patients are transferred out, particularly neonates. This region could be providing a more comprehensive Paediatric Service with Level 1 Neonatology.

Paediatric Services are currently provided at Terrace with an Outreach Program to Kitimat. Terrace has virtually no contact with Prince Rupert. Terrace has the ability to provide a Level 1 Nursery which should not be an expensive proposition with respect to capital costs. It would, however, require some supplementation of the Nursing base. This would reduce referrals out of the region.

It is recommended that:

- **An additional Paediatrician be recruited at Terrace.**
- **A true Regional Paediatric Program, including lower level Neonatology, be developed at Terrace with an outreach component and clinics as required by larger centres in the region.**

3.2.11 Internal Medicine Services

Internal Medicine Services are currently supplied in Prince Rupert and Terrace with an Outreach Program from Terrace to cover Kitimat. Inaugural attempts at developing relationships with the Queen Charlottes from Prince Rupert are being made and are commendable. The Internal Medicine Service in Prince Rupert is provided at the Intensivist end of the General Internal Medicine spectrum. A deficiency already noted is the provision of more general, lower level Internal Medicine Services and consultations, due to time constraints placed on the specialist by the provision of higher level services.

Analysis of the population base for the region as a whole suggests that four Internists could be supported. One could provide higher level Intensivist Services, with the others providing a broad spectrum of General Internal Medicine services, some Intensivist services, and some sub-specialty services.

It is therefore recommended that:

- **A further Internal Medicine specialist be recruited at Prince Rupert to offer General Medical Services to complement the Intensivist Services offered there already.**
- **Internal Medicine Services and Intensivist Services be developed in accordance with the guidelines suggested in the Prince Rupert Regional Hospital Peer Review Report.**
- **Consideration be given to the recruitment of a further Internist for the Terrace area to offer General Internal Medicine Services with an Outreach Program to other areas.**
- **Intensivist Services be concentrated in Prince Rupert on a regional collaborative basis.**

3.2.12 Psychiatric Services

Currently the region has one Psychiatric Unit based in Terrace with one Psychiatrist on staff (only just arrived at the time of the Review Team's visit). There are currently 10 beds available with a capacity for 16. This service has not been used as a regional service by the other larger centres, particularly Prince Rupert. Psychotic patients have traditionally been transferred to the Lower Mainland. This should not be necessary if a true regional service was provided. Looking at specialist ratios, the region could theoretically support a further Psychiatrist.

It is therefore recommended that:

- **Consideration be given to the expansion and augmentation of the Psychiatric Service at Terrace by the acquisition of a further Psychiatrist and the expansion of the number of beds to a maximum of 16.**

- **The Psychiatric Service at Terrace offer a true regional service with Outreach Programs.**

- **The other hospitals in the region use the Psychiatric Service at Terrace and reduce the transfer of non-forensic psychiatric patients to the Lower Mainland.**

3.2.13 Diagnostic Services

Currently the Northwest has a reasonable level of diagnostic capability in Laboratory, Radiology, and Nuclear Medicine services. A major deficiency exists in that CT Scanning is not offered in the region. A significant number of people are referred elsewhere at great cost to the individual, or their employer, for this diagnostic test. Generally accepted industry guidelines identify the minimum population base required to support a CT scanner at around 150,000. However, there are a number of relevant factors pertaining to the provision of CT Services in this region, including:

- The relative isolation of the Northwest;
- The number of people requiring this type of diagnostic test;
- The cost of transportation to the individual, their employer, and society as a whole;
- The availability of this diagnostic tool would allow more acutely ill patients to remain in their own communities;

- The Region might require recruitment of a further Radiologist experienced in this field to cope with the increase in overall Radiology Services in the Region; and

- Telemetric linkages between Terrace and Prince Rupert for CT services would maximize opportunities for regional co-operation and ensure access for the Prince Rupert Radiologist.

In view of the fact that the majority of CT Scans are done on outpatients, and that the combined population base of Kitimat and Terrace would provide service to a maximum number of people, **it is recommended that:**

- **A mid-range CT scanner be acquired for the region and sited in Terrace at the earliest possible opportunity, with evaluation of the need for recruitment of an additional Radiologist experienced in CT scanning.**

- **Telemetric capability between Terrace and Prince Rupert be developed for the transmission of CT scans, thus facilitating regional co-operation with regard to the use of the scanner.**

- **The Prince Rupert Radiologist be given privileges to use the CT scanner should he wish to avail himself of this opportunity to maintain his expertise as he is trained and experienced in CT scanning.**

3.2.14 Pathology Services

As described earlier, there is no true regional Pathology Service except in Histopathology. Although Terrace and Kitimat are reasonably well served by the current set-up (with the Pathologist being based in Terrace), Prince Rupert's situation is quite different in that a contractual arrangement exists with Pathologists at Royal Columbian to service Prince Rupert and the Queen Charlottes. The population of the region and morbidity data suggests that two Pathologists could be accommodated, particularly if they had different areas of expertise and, if they combined to provide a jointly supervised Regional Pathology Service.

It is therefore recommended that:

- **Consideration be given to developing a Regional Pathology Service under the supervision of two Pathologists, one of whom could be based in Prince Rupert with an Outreach Program to the Queen Charlottes and other areas, depending on sub-specialty interest. Reciprocal Outreach Programs could occur by the other Pathologist from Terrace.**

3.3 VISITING SPECIALISTS

The Visiting Specialist Program, whereby specialists from larger Lower Mainland hospitals visit rural communities, has been an invaluable and very successful service. With the implementation of the recommendations in this report, a careful regional overview of the visiting specialist Program should take place. This review will need to ensure that local (regional) specialists are utilized fully and that the Visiting Specialist Program is maintained and utilized where there are obvious service deficiencies (e.g., Neurology, Otorhinolaryngology, etc.).

It is therefore recommended that:

- **The Visiting Specialist Program from the Lower Mainland and Vancouver Island be reviewed and co-ordinated in such a way as to complement the Specialist Services that will be provided on a local and regional basis given the expanded specialist complement and capability in the Northwest Region.**

3.4 EMERGENCY RESPONSE PROGRAM

Concerns were raised by each community regarding the inequities of various funding sources for different types of transport. Transport within the Region is charged to the relevant hospital. Transfers out of the Region, however, are charged to the Provincial Emergency Response Service. This inequity results in no incentive to transfer patients to facilities within the Region or to maximize use of regional expertise.

To achieve true regionalization for higher level acute services, the Emergency Response Program, using ground and air transportation must be reviewed and updated so that response can be appropriate to the demand.

It is therefore recommended that:

- **The Emergency Response Program be reviewed and revamped where necessary to facilitate appropriate response to regional demands.**

3.5 CRITICAL SUCCESS FACTORS FOR REGIONAL SPECIALTY CO-ORDINATION

Regional specialty co-ordination can only be achieved if there is a will and commitment from all of the regional centres to adopt a Northwest Health Services Plan, consistent with the guidelines and recommendations in this report. Proposed change requires a shift in attitudes from some members of the Northwest communities. Historical conflicts and rivalry exist between Prince Rupert Regional Hospital and Mills Memorial Hospital at Terrace. An example was an overt and expressed desire that surgical services be centred in Terrace as should most of the "regional services" and that Mills Memorial Hospital should become the centre for most specialty services in the Northwest.

Population statistics and projections for the area do not support this proposition and, as stated previously, no one hospital in the region is of sufficient size or complexity to provide all services. There is not a large difference in the primary catchment population of either Mills Memorial Hospital or Prince Rupert Regional Hospital. The demographics of each community are similar, except for the higher native population in Prince Rupert. Kitimat also requires maintenance of its high quality primary care program with the provision of some secondary Specialist Services, and the maintenance of a sufficient number of acute care beds to support these. Kitimat's smaller catchment population, and its geographic location, limits its appeal as a secondary referral centre.

The location of services suggested in this report would ensure that each community is provided with the "core" secondary medical services in General Surgery, Internal Medicine, and Obstetrics/Gynaecology including some higher level care capability. A further mix of middle level Specialist Services would be available in Terrace and middle level and Intensivist Services in Prince Rupert.

The viability of Kitimat as an acute care hospital was questioned. The Review Team feels that there is no question that an acute care hospital is required in Kitimat to offer the services already described. This would ensure that the majority of people requiring basic hospital care (in the Kitimat area) would not need to travel outside of their community. Those requiring higher levels of care could be accommodated by the relatively short road trip to Terrace or the rather longer trip to Prince Rupert.

3.6 IMPACT ANALYSIS

This section of the report has outlined a number of potential enhancements to Specialty Services in the Northwest which will impact the resource requirements of each of the hospitals where these Specialty Services are located. It is important that before any changes are made, and particularly in the development of specialty services, impact analyses are conducted to clearly identify the financial implications. Information with regard to the predicted financial and operational impact of introducing a new specialist is readily obtainable from other hospitals and will give each hospital the information it requires in order to properly prepare for the incoming specialist. In support of proposed changes to the specialist base, **it is recommended that:**

- **Each hospital conduct financial and operational impact studies for all incoming specialists (whether new or replacements) to properly assess the impact of the specialist on the hospital's operating base.**

As discussed further in Section 7.0, the Review Team believes that there are substantial savings which would be realized through more effective utilization and improved co-ordination of health services and that these savings would be sufficient to offset the additional costs associated with enhancing the Specialty Services. The transfer of funds from existing activities to new and enhanced services will require careful planning by each of the hospitals and must be accomplished in a planned, orderly fashion with careful consideration being given to labour adjustment strategies to minimize staff disruptions.

4.0 HOSPITAL MANAGEMENT ISSUES

This Section assesses the ability of the three larger hospitals in the region to provide the type and level of services being recommended. The Review Team identified a number of consistent themes which relate to the ability of the hospitals to sustain service levels and to effectively utilize their resources. These themes include:

- Management responsibilities;
- Nursing Services;
- Labour relations issues;
- Education;
- Internal and external working relationships; and
- Working relationships with the Ministry of Health.

These themes are identified, albeit with varying emphasis, for each of the facilities in Section Two and in this section will be reviewed from a regional perspective. Specific recommendations for individual hospitals are included wherever appropriate.

4.1 ORGANIZATIONAL STRUCTURES AND MANAGEMENT RESPONSIBILITIES

There were two dominant themes identified in the hospitals which relate specifically to management responsibilities:

- The number of senior management staff required; and
- The specific assignment of responsibility for the human resources function.

Concerning the number of senior management staff required, each hospital needs to review its current allocation of functional responsibilities and identify if senior management staff are currently being used to their most effective capabilities. Three Senior Directors report to the Executive Director at Prince Rupert Regional Hospital. At both Mills Memorial and Kitimat General Hospital, four Directors report to their respective Executive Director. For hospitals of this size, it is appropriate to have two or three senior management personnel reporting to the Executive Director for co-ordination of all acute care functions.

It is, therefore, recommended that:

- **The functional responsibilities of each senior manager within the existing organizational structures, at both the Mills Memorial and Kitimat General Hospitals, be reviewed with steps taken such that the resultant structure will have two or three Directors reporting to the Executive Director. The Chief Executive Officer at Kitimat should take line responsibility for some areas which are under the jurisdiction of the senior management personnel at present.**

With respect to the second issue, each hospital needs to give further consideration to the specific assignment of responsibility for the human resources function. Human resource and labour relations issues are handled sporadically throughout the hospitals or by various senior managers, and there is no strong co-ordination of human resource functions.

A significant issue for Prince Rupert Regional Hospital is the delegation of responsibility for hospital-wide human resources. The current Executive Assistant/Human Resources Officer spends much of her time in a clerical capacity supporting the office of the Chief Executive Officer and the Board. This leaves little time to address day-to-day human resource issues or to develop new programs.

The organization chart of Mills Memorial Hospital provided to the Review Team was dated August 1990. On the chart it was noted the Director position for Personnel was vacant. During the various interviews it became apparent that not having filled the position for Director of Personnel is causing significant personnel-related problems for Mills Memorial. There is no one individual in the organization responsible for providing human resources support to the various department heads or to develop hospital-wide human resource programs.

There is confusion at Kitimat General Hospital as to who is responsible for human resource issues and contract interpretation. Apparently, various department heads are responsible for resolving grievances at steps 1 and 2. However, department heads indicate they do not have the authority to resolve grievances. All grievances within the Patient Services portfolio appear to be referred to the Director of Patient Services.

Improved labour relations would also result if the Human Resource functions at each hospital were co-ordinated by one Director.

It is, therefore, recommended that:

- **At Mills Memorial Hospital, priority be given, as part of the review of the organizational structure, to identify one Director with responsibility for all human resource functions.**

- **At Kitimat General Hospital, the role of the Director of Personnel be more clearly identified, particularly with respect to involvement in processing grievances. Further, Department Heads should assume responsibility for resolving grievances at steps 1 and 2 and be granted authority to resolve grievances at those levels.**

- **At Prince Rupert Regional Hospital, responsibility for co-ordination of all human resource functions be assigned to one of the directors (again as part of the overall review of senior management responsibilities).**

4.2 NURSING SERVICES

At Mills Memorial Hospital, there is a lack of appropriate and realistic job descriptions for nursing positions at all levels. Uncertainty exists as to who is actually in charge and as to scope of authority and responsibility.

At Kitimat General Hospital, job descriptions do not adequately reflect or describe positions of Staff Nurses. There is a generic job description which does not identify each nurse's duties or area of responsibility. Uncertainty exists as to who is in charge.

Internal working relationships between nurses and between nurses and nursing administration would be improved at Mills Memorial Hospital and Kitimat General Hospital by ensuring that the organization structure at each is clearly defined. This would lessen confusion in the workplace and, correspondingly, increase efficiencies.

Job descriptions for other employees were not reviewed by the Review Team, but based upon the current status of the Nursing job descriptions, should probably also be updated.

Earlier in this report (Section Two), an overview was given with regard to the Nursing Services being provided at each of the three hospitals. Taking these comments into consideration, along with the need to provide the necessary nursing infrastructure to support the recommendations with regard to Specialist Services, **it is recommended that:**

- **At each hospital, Nursing management structures be clearly delineated with the responsibilities and authority relevant to each position clearly stated, defined and communicated to all staff.**

- **At each hospital, Senior Nursing Managers be provided with suitable support and education opportunities to enable them to fulfil their job requirements.**

- **At each hospital, Senior Nursing Management take more responsibility and be more accountable for the day-to-day operations.**

- **At each hospital, Head Nurses be provided with adequate administrative support services to enable them to perform their clinical responsibilities.**

- **At each hospital, hospital policies and procedures be developed for admission/discharge activity, surgical bookings, and call-in/call-back guidelines.**

- **At each hospital, appropriate monitoring and analysis of overtime patterns be performed by management.**

- **At each hospital, options/alternatives be explored openly with all staff and unions before laying off personnel. Call-back and call-in expectations/requirements for remaining staff be identified and criteria established.**

- **At each hospital, staff be involved in the decision-making processes. Communications up and down the hierarchical structure should be facilitated at every level.**

- **At each hospital, labour adjustment strategies be in place before downsizing of manpower takes place if these communities are to retain a skilled manpower resource.**

- **At each hospital, job descriptions be written which reflect the actual jobs, along with their roles and responsibilities, taking into consideration proper delineation of "non-nursing" duties.**

- **At each hospital, float nurses be seriously considered with the skills to meet the requirements of services being provided on evening and nights.**

- **At each hospital, analysis of nursing skills required and available be immediately carried out, including an examination of the ability of available staff to meet these requirements.**

- **At each hospital, a formal budget for staff development/education programs be developed.**

- **At each hospital, a formal education program be implemented to upgrade and maintain skills, and that the appointment of Clinical Instructors, preferably without other unrelated job duties, should be a priority.**

- **Prince Rupert, Terrace, and Kitimat hospitals examine the feasibility of developing a Regional Education Program. and investigate the possibility of negotiating with the Northwest Community College Nursing Program to provide suitable courses for identified requirements for advanced skills/education.**

- **At each hospital, the position of Quality Assurance Co-ordinator be a full-time appointment with appropriate education and support services to fulfil the job requirements.**

- **At each hospital, Nursing Education Committees be developed.**

- **All three hospitals, Prince Rupert, Terrace, and Kitimat, forge strong links with the Northwest Community College to minimize recruitment and retention problems with respect to Nursing personnel.**

4.3 LABOUR RELATIONS

In all three hospitals, comments were expressed that clearly indicated relationships between the Unions and hospital management are less than ideal. In all three facilities, staff morale is low. Comments suggest that labour relations issues are not being dealt with in a timely manner. The financial pressures and recent or pending layoffs have further complicated union/management relationships. The lack of financial stability in each organization has contributed to job uncertainty.

It is apparent that there is a definite need for concentrated effort to improve labour relations at each of the hospitals. In addition to those recommendations made in Section 4.1, **it is recommended that:**

- **Every effort be made in each hospital to improve labour relations by:**
    - **Conducting union/management meetings on a regular basis;**
    - **Improving ongoing communications; and**
    - **Resolving identified problems in a timely manner.**

Staff Displacements

When recent layoffs occurred, there was no plan in place to assist displaced employees in their search for alternate employment, since the Ministry of Health had not yet initiated a Labour Adjustment Strategy. This strategy, which is being developed by key ministry labour and management representatives, would have been most beneficial in the transition for displaced staff since it is being structured to:

- Develop measures that will minimize layoffs;
- Ensure that every laid off employee who chooses to do so can remain in the acute care sector;
- Create additional options for employees facing layoffs; and
- Provide transitional financial assistance for laid off employees.

The layoffs to date represent budget cutbacks for the 1992-93 fiscal year. If these communities are to retain a skilled worker resource, it is essential that every effort be made to retain these employees in the community. Therefore the Review Team strongly **recommends that:**

- **Further layoffs at each hospital should not occur until such time as the Labour Adjustment Strategy is in operation.**

It should be noted that the Review Team interpreted its Terms of Reference such that it did not investigate the validity of layoff decisions made to date. However, given the recommendations made concerning implementing effective utilization management programs and those concerning reviews of the number of senior management personnel at each hospital, we refer the reader back to Section 2.4.3 regarding the recommendation to revisit layoff decisions.

4.4 EDUCATION SERVICES

Another important component of human resource management is the effective implementation and maintenance of education and training programs for staff. These hospitals must contend with comparatively high costs for off-site education, given travel expenses incurred. Financial restraints within the three facilities have to varying degrees limited onsite and off-site education opportunities. It is inappropriate to cut spending on staff education. Continuing education is necessary if hospitals are to maintain high standards of care, and adapt to changing technologies, nursing practice, and professional standards. While the Review Team recognized economic realities will continue to have an impact on the extent to which educational programs can be offered, it is important to maintain education and training as a priority and to establish plans of action on an ongoing basis.

It is recommended that:

- **Each hospital, as part of its developing human resource function, develop a co-ordinated plan of action for introducing/ maintaining/improving effective educational staff training programs on an ongoing basis.**

4.5 INTERNAL AND EXTERNAL WORKING RELATIONSHIPS

The Review Team identified a number of internal and external opportunities in each of the institutions for improvement in working relationships.

From an external perspective, the issue of improved co-ordination between the hospital and community-based health services is addressed in Section 5 of this report. Therefore, it is suffice to say that development of a more effective working relationship with community-based health services is an essential ingredient to the hospitals' ability to provide effective and efficient health care services.

From an internal perspective, the Review Team noted that, in each of the hospitals, there is a definite need for the senior management group to collectively exhibit leadership in all management areas and to become more pro-active in providing direction and guidance to the organization. The Team recognizes that, in hospitals of this size, informal working relationships and group dynamics are extremely important. However, the senior management team must assert its authority, such that hospital and medical staff recognize that administration does have responsibilities delegated from the Board to manage the hospital and to establish policies, guidelines and evaluation procedures.

For example, each hospital should examine its use of callback and overtime. Among all three hospitals, staff reported callback and overtime to be excessive, to varying degrees. Typically, the physician initiates the callback or overtime process. Complaints by staff arise when they believe the procedure requested by the physician does not require emergency attention. If the procedure is indeed not of an emergency nature, overtime costs are incurred unnecessarily. There is room for considerable savings if callback and overtime are prudently used.

It is therefore recommended that:

- **Each hospital establish criteria for justifying the use of callback and overtime, and distinguish between emergency and non-emergency procedures.**
- **Each hospital monitor callback and overtime to ensure appropriate usage.**

It is recognized that it is often difficult for Administrators to provide effective leadership in smaller organizations, because the medical staff may have an unusual amount of direct influence on day-to-day operations of the hospital. To a certain extent, there is some evidence of this characteristic in all three institutions. As a result, the boundaries of responsibility are not always respected. Having a clear understanding of each other's role and responsibilities (in the functioning of the hospital) can assist the Board, Administration, and Medical Staff to work effectively as a team. Respecting each other's role results in a reliance on each other to fulfil those responsibilities.

It is recommended that:

- **Each facility develop a "boundaries document" which outlines the scope of the roles and responsibilities for the Board, Administration and Medical Staff.**

Within each hospital, the Review Team noted the need for improved levels of communication between administration, hospital departments, and medical staff. The extent to which this is a problem varied from hospital to hospital. It was noted that specific actions are being taken to improve communication. However, there is still a need for the hospitals to carefully review their current methods of communication. Efforts should be directed to improving these methods and to developing effective feedback mechanisms, particularly between administration, hospital staff, and medical staff.

It is essential that there be effective communication in each of the hospitals between the Board of Trustees, Administration, and the Medical Staff. This communication can often be achieved through use of a Joint Conference Committee with representation from each of these groups where issued of joint concern can be openly discussed.

Therefore, it is recommended that:

- **Each of the hospitals ensure that it has an effective Joint Conference Committee with representation from the Board of Trustees, Administration, and the Medical Staff.**

Further, internal working relationships could be improved by defining planning and decision-making processes. For example, in each of the hospitals there was a perceived impression by staff that either no capital equipment planning process was in place to adequately address capital needs or that, if the plan were in place, it was being bypassed by the Medical Staff. At Mills Memorial Hospital, where the process for identifying capital equipment requirements has been developed, concerns were expressed that the Medical Staff circumvented the equipment planning process by actively pursuing the acquisition of equipment which had not received prior approval.

It is therefore recommended that:

- **The equipment planning process at each hospital be reviewed to ensure that the needs of medical staff and hospital staff are identified and prioritized in an appropriate fashion.**

- **The finalized equipment list at each hospital be endorsed by the Medical Advisory Committee.**

- **Each hospital develop a policy precluding any equipment purchases unless they have been approved or unless acquisition of the equipment is of an emergency nature.**

4.6 WORKING RELATIONSHIPS WITH THE MINISTRY OF HEALTH

Each of the hospitals has developed a working relationship with its five member Regional Team and routinely discuss outstanding operational issues with them. However, there are still opportunities for improvement in working relationships with the Ministry, particularly as it relates to advising the Ministry of corrective actions being taken on outstanding issues.

Over the past two or three years, the Health Ministry has introduced two significant initiatives to encourage hospitals to improve utilization. These programs are the Hospital Innovation Incentive Fund and the Community Partnership Program. The 1992-93 funding allocation letter identified the opportunities available to the hospitals through these two programs. There are significant opportunities in each of the institutions to submit proposals for funds from the Community Partnership and Hospital Innovation Incentive Programs. Each hospital should undertake an organized process of identifying those partnership programs which would assist in reducing reliance on inpatient beds.

There was considerable confusion at each of the hospitals over the various components of the funding allocation from the Ministry and of the impact of recent contract settlements on the overall wage cost. Each hospital should work closely with the regional team members to identify fiscal concerns and to present to the Ministry their problems relating to funding allocation.

Concerning utilization of the Hospital Innovation Incentive Fund, there is a definite need in the hospitals to develop proposals which clearly identify the costs and benefits to be achieved. The hospitals must also develop mechanisms to ensure that the proposed cost savings are in fact achieved.

It is recommended that:

- **Each hospital undertake an organized process of identifying appropriate Community Partnership Programs to make application for funding.**
- **Each hospital develop proposals clearly identifying the costs and benefits to be achieved through use of the Hospital Innovation Incentive Fund.**
- **Each hospital work closely with their regional team members to identify fiscal concerns.**

4.7 RECENT OPERATIONAL REVIEWS

The Ministry of Health undertook an operational review of Terrace Health Care Society in April 1991. Subsequently, a review by Malcolm Walker Report has occurred. The Terrace Health Care Society now view the Ministry of Health's 1991 Operational Review as being superseded. There was no evidence that the hospital has yet reviewed the Ministry's recommendations in a serious fashion.

The Report prepared by Mr. Walker is being referenced by many within the hospital and within the community. The hospital and community firmly believe there was an agreement with the Ministry of Health that if the hospital undertook to respond to the recommendations of the Report, the Ministry would reciprocate by providing the recommended funding as part of the base global funding provided to the hospital. Representatives of the hospital believe they have lived up to the spirit of the report. The hospital believes the Ministry has reneged on its obligation. Before the hospital addresses the issue of the Ministry's obligations, it is suggested that a listing of the various recommendations in the Walker Report be prepared and beside each recommendation indicate the current status. In doing so, the hospital should recognize there is a lack of appropriate progress in several important areas, such as the development of impact analysis when significant medical specialties are being contemplated, and the development of a demonstrable utilization management program.

5.0 COMMUNITY-BASED SERVICES

In this section, community-based services with respect to a number of programs are reviewed. Included in this review are: Continuing Care, Public Health, Mental Health, Alcohol and Drug, Seniors' Services, and Rehabilitation Services. The discussion includes observations and comments on opportunities for greater consultation and co-ordination between service provider organizations.

Review Team members solicited input and received submissions from representatives of the hospitals and those community-based agencies (both public and private) having a health focus. Stakeholder groups consulted in the communities of Prince Rupert, Terrace, and Kitimat are outlined in Table 7.

In addition, many worthwhile programs are offered through, for example, the Terrace and District Community Services Society (TDCSS), but are not listed in Table 7 because the program's focus is not predominantly a health focus.

Other community-based services, while not predominantly health related, do address the ongoing needs of people in the communities reviewed. For example, both Kitimat and Terrace address the special needs of children through the Child Development Centres and Family Resource workers; Prince Rupert depends on the Infant Development Program and a preschool that takes special needs children. As well, there are services for seniors in all three communities such as Handi-dart, Meals-on-Wheels, Seniors' Activity Centres, and limited low-cost seniors' housing.

Representatives were asked to comment on the availability, accessibility and adequacy of community health services; whether they could identify any duplication or overlap or absence of services; the working relationship between community-based agencies and between hospitals and community-based agencies; and organizational structure and funding sources.

Within the time frame allowed for this study, and consistent with the Terms of Reference, Review Team members sought information that would identify and support recommendations pertaining to "Changes to services or the way services are provided to ensure the highest quality of health care in the Northwest Region. . ." and to "improv(ing) consultation and co-operation within the region. . .between hospitals and community-based services". The team did not conduct a thorough operational review of each community-based service, given our limited mandate.

It became apparent that the number of recommendations that could be made should be confined to objectives that may not be achieved through the traditional channels. By way of example, in *most* instances where the Review Team heard that a service was understaffed, they decided to leave it to the interested parties to make application to the appropriate administrative authorities (exceptions are noted below). Where the Team heard that certain projects had been undertaken, e.g., a Community-Hospital Partnership Program Application, they decided to defer to the established process, rather than commenting on the application by way of a recommendation.

Some community-based services such as those provided by the Skeena Health Unit out of Terrace and by the Mental Health program based in Prince George had identifiable gaps in services or had future plans for increased FTEs that will address some of the community deficits.

Table 7

RANGE OF COMMUNITY-BASED SERVICES PROVIDED IN THE NORTHWEST REGION*

SERVICE	PRINCE RUPERT	TERRACE	KITIMAT
PUBLICLY FUNDED (partially or wholly)			
Hospital	PRRH	MMH	KGH
Public Health	SHU	SHU	SHU
Continuing Care: • Home Care Nursing • LTC: Personal Care Intermediate Care	 SHU None Acropolis Manor	 SHU None TVL	 SHU None None
Community Nutrition	SHU	SHU	SHU
MSB Nurse (Federal)	MSB (H&W Can)	MSB (H&W Can)	None
Mental Health	MHU	MHU	MHU
A & D Counselling	PR A&D	NW A&D	NW A&D
Homemaker	Home Support Association	Terrace Home Support Service (TDCSS)	Home Support Services
Social Services	MSS	MSS	MSS
CDC	None	CDC	CDC
VOLUNTEER/PUBLIC			
Healthy Communities	(No)	(Yes)	(Yes)
AIDS Support Group	(Yes)	(No)	(No)
PRIVATE			
Assessment and Referral Service	(Yes)		
Private Lab	(No)	(Yes)	(No)
Private Physiotherapy	(Yes)	(Yes)	(No)

* Abbreviations used in this table are defined as follows:
PRRH - Prince Rupert Regional Hospital; MMH - Mills Memorial Hospital; KGH - Kitimat General Hospital; SHU - Skeena Health Unit; LTC - Long Term Care; TVL -Terrace View Lodge; MSB - Medical Services Branch; H&W - Health and Welfare; MHU - Mental Health Unit; A&D - Alcohol and Drug; PR - Prince Rupert; NW - Northwest; TDCSS - Terrace & District Community Services Society; MSS - Ministry of Social Services; CDC - Child Development Centre.

Source: Review Team interviews with hospital and community-based health care providers.

5.1 CONTINUING CARE

The Continuing Care Program includes Long-Term Care Facilities, Homemakers, and Home Nursing Care. It provides home nursing care under the direction of a physician and covers five areas encompassing 11,000 square miles. Staffing for a Skeena Health Unit for the care programs is considered adequate, as long as the present admissions stay the same, with the 1992-93 budget increase of an additional 3 FTEs. These positions are being used to assist with Long Term Care in the Queen Charlottes, rehabilitation, Home Nursing Care and an Assistant in Smithers.

The general feeling by the program administrator is that although their Home Nursing Care Program, which provides home nursing care under the direction of a physician, is under utilized, there is a need for increased homemaker support in all three communities, especially for emergency placements and for palliative care patients. During the 1992 HEU strike and subsequent bed closures, the impact on the Home Care Program was minimal. No extra staff was hired, although contingency plans to do so were in place. In all three communities a number of factors contributed to the under utilization of the Home Nursing Care Program. They include:

- A lack of physician awareness of the program availability and scope, and an apparent reluctance to use it;
- No push by the hospitals for discharge planning and freeing up the beds; and
- The lack of a hospital Social Worker to co-ordinate the discharge planning and utilization of the appropriate community resources.

It is recommended that:

- **Each hospital develop standardized educational programs in conjunction with the Home Nursing Program. These programs should inform hospital nursing staff and physician staff regarding the appropriateness of Home Nursing Care.**

- **Each hospital institute educational home care/hospital/physician staff rounds to support increased utilization of Home Care Programs.**

As outlined in Section 2.4.2, the Review Team also recommends that Mills Memorial Hospital and Prince Rupert Regional Hospital each increase the social work staffing by 1 FTE to co-ordinate discharge planning and the more effective use of appropriate community resources.

5.2 PUBLIC HEALTH

The Public Health Program (Preventive Program) encompasses a wide range of activities, including:

- Reporting sexually transmitted and communicable diseases;
- Child/youth immunization;
- School health programs;
- Identification and follow-up of at-risk mothers and their babies;
- Postpartum visits in hospital of all mothers with new babies in order to identify those at-risk;
- Seniors wellness programs; and
- General prevention programs (e.g., needle exchange programs, Hepatitis B immunization).

Services are available from 0830-1630 hours, five days a week and encompasses eight hospitals and seven school districts. There are gaps in all three communities with respect to:

- Adolescent programs (e.g., youth health clinics to address teen pregnancies, sexually transmitted diseases);
- Accident and injury prevention programs for children and youth;
- School health services; and
- Discharge planning from the hospital.

A proposed increase in public health nurses would help address these issues. However, the positions are on hold until the Ministry of Health's Labour Adjustment Strategy is in place. This reinforces the need for speedy implementation of this program as noted elsewhere in this report.

5.3 MENTAL HEALTH

The Mental Health Program is administered through Prince George. Services are available in all three communities and are directed to children and families with acute needs; children and youth preventive programs in the schools; and to adult and elderly individuals with acute and chronic mentally ill treatment needs.

The requirements for this program are unique in the Northwest since there is a lack of resources in other areas that overlap with Mental Health Services. For example, due to the lack of adequate drug and alcohol counsellors and the lack of resources from the Psychiatric Outpatient Program in Prince Rupert to assist with marital counselling, Mental Health has helped to fill this void.

The program is administered through Prince George, a difficult place to access from any of the three areas since the road distance is long and air travel goes is via Vancouver. Continued improved program direction and cohesion would be greatly assisted through an administrative office being located in either Terrace or Prince Rupert.

The Mental Health Program has received a major increase in funding in order to address historic and long-term short-falls. In all three communities the programs were described as currently well-funded and able to meet the majority of the needs of the areas. There is, however, a need for increased space for the staff in Terrace and Prince Rupert.

5.4 ALCOHOL & DRUG-RELATED SERVICES

Prince Rupert Alcohol and Drug Services currently employs one FTE Counsellor. A further 0.5 FTE substance abuse prevention worker will start working in the fall of 1992 for one of the two high schools. Northwest Alcohol and Drug Services has one FTE Counsellor working at their Terrace Office, serving a dual role as Substance Abuse Prevention Worker in the (Terrace) School Prevention Program. A further one FTE Counsellor works at their Kitimat Office, along with a 0.5 FTE Substance Abuse Prevention Worker in the (Kitimat) School Prevention Program. Through their respective societies, these workers report to the Prince George Alcohol and Drug Program. In addition, Prince Rupert has a privately-run Assessment and Referral Service which offers substance abuse counselling through Employee Assistance Programs, purchased by some Employers.

There are no proper detoxification facilities in the Northwest. Likewise, there are no community Residential Treatment Centres.

Patients present at hospitals in Prince Rupert, Terrace and Kitimat, requiring detoxification or requiring treatment for substance abuse-related injury or disease. Detoxification occurs on the medical wards -- by all accounts a less than desirable setting for patients undergoing withdrawal. Unfortunately, the detoxification provided in this setting is strictly medical detoxification. The hospitals do not employ alcohol and drug counsellors and, consequently, inpatients do not receive counselling. Without counselling, the patient may repeat the cycle of substance abuse, hospital admission and release, only to fall prey to alcohol and/or drugs again.

Some individuals are confined to jail while undergoing withdrawal, again without counselling, or adequate referral, and certainly in a setting not conducive to treatment.

Mental Health workers do not have a mandate to counsel clients with substance abuse. However, it is not uncommon for a client to present with the underlying problems of substance abuse. Those requiring substance abuse counselling should be seen by the Alcohol and Drug Counsellor (described above).

Volunteer groups throughout the Northwest, including Alcoholics Anonymous, Narcotics Anonymous, Co-dependants Anonymous, Adult Children of Alcoholics and Children of Alcoholics, provide valuable peer support. However, clients do not receive professional alcohol and drug counselling or rehabilitation in this setting.

In 1991, 80 clients were referred out of Prince Rupert for treatment and/or detoxification. Clients must leave their families and communities to travel to Residential Treatment Centres such as those on Vancouver Island or in the Okanagan, Fraser Valley or Lower Mainland. The closest treatment centre is in Prince George. While commenting on the absence of regional residential treatment and the resultant referrals out-of-town, one representative noted that it should not be the responsibility of Greyhound Bus Lines to help people through their detoxification.

Alcohol and Drug Abuse is a well-documented problem in the Northwest, adversely affecting the lives of the abusers, their families and the communities in which these people live. Yet, there remains the perennial lack of recognition and/or lack of resource dedication by authorities to address this enormous problem at both a preventative level and treatment level.

It is therefore strongly recommended that:

- **The Prince George Alcohol and Drug Program, with support from the Ministry of Health, undertake a needs assessment for Alcohol and Drug Counsellors and Substance Abuse Prevention Workers in all three communities, with a view to increasing its staff complement.**

- **A Northwest Regional Detoxification/Residential Treatment Centre be established.**

- **The Prince George Alcohol and Drug Program, with support from the Ministry of Health, undertake a review of their clients' needs in all three communities so as to determine:**

    - **the appropriate location for a Northwest Regional Detoxification/Residential Treatment Centre, and**
    - **the services such a Centre should provide.**

5.5 REHABILITATION SERVICES

Rehabilitation Services typically include services such as those provided by physiotherapists, occupational therapists, orthotists, prosthetists, audiologists, speech language pathologists, music therapists, art therapists and recreational therapists. The Rehabilitation Services provided to the region are as follows:

- The Skeena Health Unit provides occupational therapy, audiology and speech language pathology, all of which take place outside the hospital setting.
- Prince Rupert Regional Hospital provides physiotherapy and occupational therapy to inpatients. Physiotherapy is available to outpatients. There is one privately-operated physiotherapy clinic in Prince Rupert.
- Mills Memorial Hospital provides only physiotherapy to inpatients and outpatients. There is one privately-operated physiotherapy clinic in Terrace.
- Kitimat General Hospital provides both physiotherapy and occupational therapy to inpatients and outpatients.

The Review Team heard repeatedly that the physiotherapy and occupational therapy needs of these communities are greater than the therapy services provided. Low staffing levels appear to result in long waiting lists, elimination of programs, or absence of programs. The Review Team is convinced that improvements are needed to reduce outpatient waiting lists and provide the appropriate range of rehabilitation services. It is suggested that a committee be established for the purpose of defining the appropriate range of rehabilitation services and staffing complement for the region. The committee should be comprised of a physiotherapist, occupational therapist, administration representative from each of the three hospitals, and an occupational therapist and administration representative from the Continuing Care Division of the Skeena Health Unit. In turn, the Ministry of Health should evaluate the committee's report with a view to increased funding for Rehabilitation Services.

Hospitals fund outpatient physiotherapy services from their global budgets, given they are unable to bill the Medical Services Plan on a fee-for-service basis. Consequently, there has been a trend for hospitals to reduce this service in their efforts to balance budgets. Private clinics do not necessarily provide the full range of hospital physiotherapy services, as is the case in Prince Rupert.

The Review Team holds the view that health care ought to be publicly administered, consistent with the principles of the Canada Health Act. Properly co-ordinated community and regional planning would ensure that necessary health care services are available through public institutions and agencies. Appropriate therapy should not be dependent upon a patient's ability to pay. Paradoxically, while private clinics are entitled to bill the Medical Services Plan, hospital outpatient physiotherapy departments are not. This inconsistency creates unequal access and the potential for a decrease in hospital-based physiotherapy services.

It is recommended that:

- **The Ministry of Health review its funding methodology to ensure availability of outpatient occupational and physiotherapy services to each of the three communities.**

5.6 SENIORS' SERVICES

There have been an increasing number of people returning to the region to retire who require specialized services as they grow older (e.g., Handi-dart, home support services and housing). In each of the communities there are intermediate and extended care facilities for those requiring ongoing supervised care. However, a consistent theme identified in all three communities is the need for appropriate, affordable seniors' housing. At present, there is inadequate seniors' housing complexes that provide safe, affordable housing with larger units than bachelor suites. The Review Team also heard requests for a gathering place within the housing complex for social activities, with a dining room/restaurant, and access to a scheduled wellness health clinic.

As a result of older adult citizens choosing to reside and retire within the region, there will be an increased need to support the growing seniors population. Services should allow seniors to stay in homes that are appropriate in size, affordable, and which stimulate social interaction.

Therefore it is recommended that:

- **The Ministry of Health and Seniors Services review seniors' housing needs in all three areas and, with community involvement, develop a planned building schedule for affordable seniors' housing.**

In all three communities and in the three hospitals, there was request for a regional Geriatric Assessment and Treatment Team to address the needs of those seniors requiring intense assessment and a treatment plan to assist them in staying in their homes. However, the relatively few numbers of seniors in the Northwest (6% or less of the population of which the majority are healthy) and their geographically-scattered residences do not justify such a team at this time.

5.7 CONSULTATION AND CO-OPERATION

Generally speaking, the parties interviewed by the Review Team acknowledged the value of communicating with other health care providers, but showed various levels of enthusiasm to do so.

The most commonly reported working relationships existed between the public health nurse and hospital, the home care nurse and hospital, and the Medical Services Branch (MSB) nurse and hospital. In these examples, the contact at the hospital is the nursing staff.

The Review Team asked parties to speculate as to the reason(s) for a lack of communication. The answers ranged from an absence of effort, to failed attempts to establish a liaison, to perceived threat to independence of operation, to lack of overall planning. Further, the Review Team and others observed some doctors are not well-acquainted with the features of community-based services, such as the hours of operation and scope of the home nursing care program.

In addition, the existence of separate funding and separate bureaucracies were cited as obstacles to co-ordination of efforts. Often the response was that direction from "somewhere" was needed.

The Review Team asked parties to suggest a mechanism for improved consultation and co-operation. Responses included:

- Expanding hospital boards into community health boards including community delegates, and where each community health board would send a representative to a regional health board;
- Hospital discharge planning which includes community-based agency input;
- Players need to talk and plan in a friendly environment, locally driven;
- Ministry of Health should provide leadership to define roles of health care providers, and to define their working relationships.

It is interesting to note that health care providers have demonstrated a new/renewed interest in consultation over these past few months. For example, there is now ongoing communication between the regions' hospital administrators; there has been a meeting of hospital representatives in the Northwest where, in part, the North Coast Regional Health Plan has been "dusted off"; Kitimat's Healthy Communities organized an open Health Care Forum, an educational event, for September, in which 160 invitations were extended; the Skeena Health Unit's Medical Health Officer was invited to meet with the hospital administrators and hospital board representatives in September.

Dialogue between health care partners is a foundation upon which to build sound working relationships, and efforts to initiate this dialogue are applauded.

It is recommended that:

- **Education of community health care providers (as to the services provided by other agencies) take place on an annual basis through joint in-service sessions, Health Care Forums, and/or by familiarization with the community publication entitled, "Community Resource Book".**

6.0 IMPROVED CO-ORDINATION OF HEALTH PROGRAMS

One of the terms of reference for the Northwest Review is to "make recommendations to improve consultation and co-operation within the region both between hospitals and between hospitals and community-based services". Furthermore, the Review Team was asked to recommend "changes to the way services are provided to ensure the highest quality of health care in the northwest region consistent with available funds."

Within that context the Review Team assessed the opportunities for changes in the approach to governance of the health care programs in the region and to the planning roles undertaken by each provider organization. This section identifies a number of issues related to improved co-ordination of health programs from an individual community as well as a regional perspective. A number of alternate models of improved service co-ordination are presented.

The review identified a number of issues which must be considered in any discussion on the regional alternatives for the area, including:

- The strong parochial attitudes currently existing among the three communities of Terrace, Kitimat and Prince Rupert;
- The lack of any effective regional health co-ordinating function in the area, attributable, at least in part, by the existence of two Regional Hospital Districts;
- The lack of significant co-ordination of related health and social services programs within each of the communities, let alone between communities;
- The difficulties arising from the existing Ministry of Health approach to administration and funding of the various health programs being offered in the area; and
- The problem of lack of co-ordination between the provincial and federal authorities with respect to provision of services to natives and non-natives.

6.1 ANALYSIS OF ISSUES

It is apparent that traditionally there has been a noticeable lack of co-ordination between many of the health care providers in the Pacific Northwest. The three hospitals have operated in a relatively autonomous manner, preferring to either work independently or to look to Vancouver or other larger centres for assistance whenever required. There has been minimal, if any, co-ordinated medical manpower planning particularly in the area of provision of specialty services. As a result, opportunities for sharing a broadly based regional specialty service (offering a sustainable base for operation and adequate back-up support and relief) have been missed.

This lack of co-ordination between the hospitals has also evidenced itself in the lack of planning for other types of regional services (e.g., diagnostic services, biomedical services, etc.), and in the inadequate development of regional education and training programs for staff.

It is also apparent that there is very little co-ordination in some segments of the community-based health services with hospital-based activities. In particular there is a distinct lack of discharge planning from the hospital to community-based health services. As was discussed previously in our analysis of the community-based services, this has compounded problems in the provision of efficient and effective health care.

Another significant constraint to effective regional co-ordination is the current disparate approach to funding for the health care services being offered in the Northwest. The fact that funding is being received from different functional groups within the Ministry of Health, from different Ministries within the provincial government and from the federal government results in a lack of any identified "balance" in the distribution of health care funds.

6.2 ALTERNATE APPROACHES TO EXISTING DELIVERY STRUCTURES

The identified problems in the co-ordination of health care services in the Northwest indicate the need for basic changes in the approach to co-ordination and management of health services in the area. Significant changes in the delivery of health services must be made if the traditional parochial interests are to be replaced with a new spirit of co-operation and joint planning. A new type of community and\or regional co-ordinating body must be developed.

This section of the report identifies a number of alternate approaches which might be considered. It outlines the relative advantages and disadvantages to alternate management models. The alternative approaches are as follows:

1. Regional Health Council

Under this alternative, full governance responsibility for the provision of all health programs and services within the area would be vested in one regional council. This body would control all of the health care funds designated to the area and have full responsibility for the management of all health-related programs.

Advantages: This structure would:

- facilitate the co-ordination of resource allocation to the various health care programs and services currently being provided in the area;
- ensure regional autonomy and decision-making concerning the future development of health services;
- improve utilization of existing programs and services through enhanced co-ordination of activities; and
- develop a strong, integrated body which could more effectively negotiate with the Ministry of Health concerning health service resources required for the area.

Disadvantages:

- Success is highly dependent upon strong regional co-operation among the health care providers, a characteristic which is not currently prevalent.
- Loss of local autonomy in the determination of health-related services.
- Perceived difficulties in establishing regional funding for health care, given the current multiplicity of funding sources for existing services.
- Perceived difficulty in adopting an integrated regional approach to the provision of health services, given the existing Ministry of Health management and funding structure.

2. Regional Health Planning Council

This is a modification of the previous alternative in that such a council would be given responsibility for the co-ordination of all regional health services **planning**, but all management responsibilities would remain with the existing providers.

Advantages:

- Less disruption to the existing system, thus enhancing the possibilities for short-term success.

Disadvantages:

- Perceived disadvantage of a council trying to direct future developments of health services without having funding control.
- Limited opportunity for local operational co-ordination of health services.

- Potential establishment of another layer of bureaucracy in the system.

3. Community Health Boards

Under this alternative, local communities would take the initiative in planning and managing their health services. The Community Health Board would be provided a "funding envelope", and would have full governance responsibility for all health programs and services within the community.

Advantages:

- Strong community involvement in planning, managing and co-ordinating local health services.
- Maximum opportunity to improve utilization of existing services through local co-ordination of activities.
- Maximum opportunity to identify current "gaps" in the health services being provided in the community.
- Significant opportunity for improvement in the overall quality of care being provided through better provision of a continuum of care to each patient.

Disadvantages:

- Significant disruption to existing local structures, including dissolution of individual Boards and elimination of existing regional approaches to certain services (public health, mental health, etc.)
- Limited direct opportunity for enhancing regional co-ordination, as opposed to local community co-ordination, in the short term.

- Perceived difficulty in adopting a local approach to health services planning and management given the existing Ministry of Health organizational and funding structure.

4. Community Health Planning Boards

This again is a modification of the previous alternative, whereby **planning** responsibilities would be delegated to the Community Health Board but management would still be the responsibility of individual providers of the different health services.

Advantages:

- Strong community involvement in the planning of local health services and identification of existing gaps in services.

Disadvantages:

- Potential inability of the local planning council to effectively control future directions of health care planning because of lack of funding control of programs and services.
- Potential introduction of another layer of bureaucracy through establishment of a local planning council while maintaining existing management structures.
- Limited opportunity for enhancing regional co-ordination.

6.3 ANALYSIS OF ALTERNATIVES

The Review Team supports the concept of full regional co-ordination of the health care programs and services in the Pacific Northwest. This is seen to be best achieved through the establishment of a regional council or co-ordinating body which would have responsibility for the overall management of health services. However, the Review Team also recognizes that there are many existing factors which must be considered in determining the short-term feasibility of establishing such a council. These factors include the current strong parochial attitudes, the lack of any existing co-ordinated regional planning, the disjointed sources of funding, and the lack of any co-ordinated medical manpower planning.

While the Review Team, therefore, recommends that the long-term goal be full regional co-ordination, it believes that the most appropriate short-term action would be the establishment of Community Health Boards. These Boards could introduce the basic principles of a co-ordinated approach to the delivery of health care. If these Community Boards are to be fully effective they must have the maximum opportunity to co-ordinate not only the planning aspects but also the operational directions. The Team, therefore, proposes that the Boards be given the responsibility for both the planning and operational co-ordination of health care in the community.

It is, therefore, recommended that:

- **Community Health Councils be established in Prince Rupert, Terrace, and Kitimat and that these Councils be given the responsibility for the overall co-ordination and management of health care programs and services.**

The Review Team recognizes that Community Health Councils such as these, can only be effective if they deal on a co-ordinated basis with the funding agencies. Joint co-ordination between Councils is essential in ensuring that the Councils have the maximum opportunity to allocate resources effectively within their respective communities.

Therefore, it is recommended that:

- **The Ministry of Health establish a co-ordinating office to integrate all Ministry of Health interaction with the Community Health Boards and that**

funding for all provincially-sponsored health services be provided on an integrated basis through this co-ordinating office.

6.4 IMPLEMENTATION

If the creation of Community Health Boards and the related development of more co-operative working relationships among health care providers is to be successfully introduced, it is essential that there be a strong, focused approach to implementation of this new structure. The Review Team believes that, because of the existing rivalry and competition between local health care professionals and the difficulties which will be encountering in endeavouring to unravel the current bureaucratic complexities, it will be necessary to assign the co-ordinative role to one individual who will work closely with the various health care groups to develop a community focused governance structure. It is suggested that an independent co-ordinator could also diffuse any potential perception of "empire building" which might arise if any of the current health providers attempted to unilaterally take the initiative in linking all health services.

Therefore it is recommended that:

- **A regional co-ordinator be appointed under contract from the Ministry of Health for a period not to exceed three years and that this individual be assigned the responsibility of ensuring that greater community and regional co-operation in the health services in the Northwest is developed, including the development of Community Health Boards in Prince Rupert, Terrace and Kitimat.**

7.0 CONCLUSIONS

The Review Team, composed of representatives from hospital management, management consulting, and the three major health care unions in the province (HEU, HSA, and BCNU), believe the composition of the team was valuable to the review process. This team concept was the first experiment of this kind. Management and union representatives worked well together and felt the dialogue and discussion was mutually beneficial in clarifying misconceptions and in understanding values and relative stakeholder positions. Should other reviews of this type occur, the Team would strongly recommend that a similar composition be considered.

Throughout this report, the Review Team has identified a number of areas where enhancements or restructuring are being proposed to specialty programs, hospital services, and community health programs. While the Team has not been requested in the Terms of Reference to provide cost analyses of these changes, it has been asked to consider such changes within the availability of existing health care funds in the province.

The Review Team has identified, throughout this review, many areas where significant savings in existing resources could be realized through improved utilization, enhanced discharge planning, better management, and improved co-ordination of health services. The Review Team suggests that, if these areas are properly addressed and the subsequent savings realized, there may be considerable funds available to be transferred to those programs and services requiring additional resources while still maintaining required services in the region.

This conclusion reinforces the need for very careful consideration of health planning and management in the area. The transferring of funds, staff, etc. from one program to another will require significant planning and co-operative working relationships. The Labour Adjustment Strategy may have to be used to the maximum and management and labour will have to work very closely together to minimize staff disruptions and to ensure that a strong professional staff base is maintained in the region. Hospital Boards will have to demonstrate a commitment to strong leadership, particularly in the development of utilization management programs. The medical communities will have to make a commitment to support these programs and to adjust their patterns of practice accordingly. Community health providers will have to make a commitment to work in close co-operation.

Summary

The Review Team is convinced that if the health care providers work together in close collaboration, share resources and plan effectively, each of the communities in the Northwest will be able to provide appropriate health programs and services to the residents in the area.

As identified in this report, Prince Rupert should be able to enhance its specialty base through the addition of an Orthopaedic Surgeon, certified Anaesthetist, Internal Medicine specialist and the potential addition of a second General Surgeon (if future demand warrants it). Community services could be enhanced through better education for and communication with hospital staff, medical staff, and community personnel regarding the hours of service offered and the scope of the services. As well, an admission/discharge process that addresses the continuity of care for patient and family within hospital and community, co-ordinated by a hospital-based social worker should enhance patient care and assist with bed utilization.

Terrace should be able to maintain and enhance its base of specialty services, and by incorporating additional services in Ophthalmology, Otolaryngology, Paediatrics, Internal Medicine and Psychiatry should be able to provide a much broader regional service to the other communities. In addition, the placement of a CT Scanner in Terrace with strong linkages to Prince Rupert would enhance the provision of diagnostic services to the whole Northwest. Community services utilization should be improved with the development of a community/hospital education/communication link and the hiring of a hospital-based social worker to co-ordinate the admissions/discharge planning process.

Kitimat should be able to maintain an acute care hospital providing an appropriate range of general services and emergency support to the community. Operating room programs should be maintained through the incumbent General Surgeon, Visiting specialists and Family Practitioners.

Inpatient services should be supported by 20-25 acute care beds, preferably in a new facility which integrates inpatient and community health programs. Community services appear adequate, however, there is a need to educate the hospital and medical staff regarding the scope of the community programs for better utilization.

In all three areas there is a very great need for Drug and Alcohol Services and for a Rehabilitation Centre. This should be addressed on a regional basis. As well, in all three areas there should be future planning for affordable, appropriate seniors' housing.

Once the three communities have developed a co-ordinated base of health services as described above, they should be able to strengthen regional co-ordination and planning, thus ensuring that they are providing optimal levels of health care to the region.

7.1 LISTING OF RECOMMENDATIONS

HOSPITAL-BASED SERVICES

We recommend that:

- The Administration and Medical Staff at Prince Rupert Regional Hospital discuss effective utilization of the Operating Rooms in an open manner and that the hospital develop an OR booking system that will meet mutual needs.

- Mills Memorial Hospital and Medical Staff develop a target wait list by surgical specialty. When the wait list falls below the target and the hospital begins to encounter operational inefficiencies, OR resources should be reduced or the OR time reassigned to other physicians for the next several months.

- The Administration and Medical Staff at Mills Memorial Hospital discuss effective utilization of the Operating Rooms in an open manner and that the hospital develop an OR booking system that will meet mutual needs.

- Mills Memorial Hospital review the Food Services operation with particular emphasis on professional time required to support not only dietary counselling, but leadership and direction for the Department.

- The Kitimat General Hospital and Medical Staff develop a target wait list by surgical specialty. When the wait list falls below the target and the hospital begins to encounter operational inefficiencies, OR resources should be reduced or the OR time reassigned to other physicians for the next several months.

- The Administration and Medical Staff at Kitimat General Hospital discuss effective utilization of the Operating Rooms in an open manner and that the hospital develop an OR booking system that will meet mutual needs.

- Kitimat General Hospital review the payroll card system and delegate responsibility for card completion to payroll personnel.

- The Prince Rupert Regional Hospital hire one FTE Social Worker to co-ordinate the continuity of patient care prior to, and following, hospital admission.

- The Mills Memorial Hospital hire one FTE Social Worker to ensure timely and effective discharge planning.

- The Kitimat General Hospital administration and key community-based agencies establish a hospital-based discharge planning process.

- Mills Memorial and Kitimat General Hospitals revisit their decisions to lay off staff in light of opportunities for improved utilization management and related savings and in the broader context of the full range of recommendations arising out of this review.

- Each hospital Board establish, as a priority, policies for the development of a utilization management program, and each hospital Administration and Medical Staff use these policies to develop comprehensive utilization management programs.

- Each hospital Board take an active role in monitoring the effective implementation and evaluation of the impact of such a program on resource consumption.

3.0 REGIONAL SPECIALIST SERVICES

We recommend that:

- An analysis be performed of the demand, case mix, and workload of the current General Surgeon at Prince Rupert and that a further General Surgeon be recruited for Prince Rupert, should sufficient demand exist.

- Outreach Programs be developed in this and other specialties to service Prince Rupert and the Queen Charlotte Islands.

- The Orthopaedic Service be transferred from Kitimat to Prince Rupert, recognizing that Prince Rupert Regional Hospital will have sufficient surgical bed capacity to absorb this service if the recommendations in the Peer Review Report are followed.

- Adequate funding be transferred to Prince Rupert Regional Hospital to inaugurate support and maintain a full Orthopaedic Service for the region. Funding should include allocations appropriate for major joint replacements and uncomplicated spinal surgery. Small joint replacements and more complex spinal surgery should be referred out to a tertiary centre.

- The bed requirements at Kitimat General Hospital be reviewed in conjunction with the transfer of the Orthopaedic Service and that a target of age/sex adjusted bed ratio of 2.75 beds per thousand population (which would equate to 24-26 beds for the immediate population) be established.

- Ophthalmology Services be developed at Terrace to include cataract and external ocular procedures but not including a retinal service.

- Consideration be given to the acquisition of a specialist in Anaesthesia to support the Orthopaedic and Intensivist Services in Prince Rupert.

- The Ear, Nose and Throat specialist from Terrace be encouraged to develop a service to Prince Rupert.

- The already excellent Urological Outreach Program from Terrace to Prince Rupert and Kitimat be maintained but that consideration be given to performing more surgical services in Prince Rupert.

- An additional Paediatrician be recruited at Terrace.

- A true Regional Paediatric Program, including lower level Neonatology, be developed at Terrace with an outreach component and clinics as required by larger centres in the region.

- A further Internal Medicine specialist be recruited at Prince Rupert to offer General Medical Services to complement the Intensivist Services offered there already.

- Internal Medicine Services and Intensivist Services be developed in accordance with the guidelines suggested in the Prince Rupert Regional Hospital Peer Review Report.

- Consideration be given to the recruitment of a further Internist for the Terrace area to offer General Internal Medicine Services with an Outreach Program to other areas.

- Intensivist Services be concentrated in Prince Rupert on a regional collaborative basis.

- Consideration be given to the expansion and augmentation of the Psychiatric Service at Terrace by the acquisition of a further Psychiatrist and the expansion of the number of beds to a maximum of 16.

- The Psychiatric Service at Terrace offer a true regional service with Outreach Programs.

- The other hospitals in the region use the Psychiatric Service at Terrace and reduce the transfer of non-forensic psychiatric patients to the Lower Mainland.

- A mid-range CT scanner be acquired for the region and sited in Terrace at the earliest possible opportunity, with evaluation of the need for recruitment of an additional Radiologist experienced in CT scanning.

- Telemetric capability between Terrace and Prince Rupert be developed for the transmission of CT scans, thus facilitating regional co-operation with regard to the use of the scanner.

- The Prince Rupert Radiologist be given privileges to use the CT scanner should he wish to avail himself of this opportunity to maintain his expertise as he is trained and experienced in CT scanning.

- Consideration be given to developing a Regional Pathology Service under the supervision of two Pathologists, one of whom could be based in Prince Rupert with an Outreach Program to the Queen Charlottes and other areas, depending on sub-specialty interest. Reciprocal Outreach Programs could occur by the other Pathologist from Terrace.

- The Visiting Specialist Program from the Lower Mainland and Vancouver Island be reviewed and co-ordinated in such a way as to complement the Specialist Services that will be provided on a local and regional basis given the expanded specialist complement and capability in the Northwest Region.

- The Emergency Response Program be reviewed and revamped where necessary to facilitate appropriate response to regional demands.

- Each hospital conduct financial and operational impact studies for all incoming specialists (whether new or replacements) to properly assess the impact of the specialist on the hospital's operating base.

4.0 HOSPITAL MANAGEMENT ISSUES

We recommend that:

- The functional responsibilities of each senior manager within the existing organizational structures, at both the Mills Memorial and Kitimat General Hospitals, be reviewed with steps taken such that the resultant structure will have two or three Directors reporting to the Executive Director. The Chief Executive Officer at Kitimat should take line responsibility for some areas which are under the jurisdiction of the senior management personnel at present.

- At Mills Memorial Hospital, priority be given, as part of the review of the organizational structure, to identify one Director with responsibility for all human resource functions.

- At Kitimat General Hospital, the role of the Director of Personnel be more clearly identified, particularly with respect to involvement in processing grievances. Further, Department Heads should assume responsibility for resolving grievances at steps 1 and 2 and be granted authority to resolve grievances at those levels.

- At Prince Rupert Regional Hospital, responsibility for co-ordination of all human resource functions be assigned to one of the directors (again as part of the overall review of senior management responsibilities).

- At each hospital, Nursing management structures be clearly delineated with the responsibilities and authority relevant to each position clearly stated, defined and communicated to all staff.

- At each hospital, Senior Nursing Managers be provided with suitable support and education opportunities to enable them to fulfil their job requirements.

- At each hospital, Senior Nursing Management take more responsibility and be more accountable for the day-to-day operations.

- At each hospital, Head Nurses be provided with adequate administrative support services to enable them to perform their clinical responsibilities.

- At each hospital, hospital policies and procedures be developed for admission/discharge activity, surgical bookings, and call-in/call-back guidelines.

- At each hospital, appropriate monitoring and analysis of overtime patterns be performed by management.

- At each hospital, options/alternatives be explored openly with all staff and unions before laying off personnel. Call-back and call-in expectations/requirements for remaining staff be identified and criteria established.

- At each hospital, staff be involved in the decision-making processes. Communications up and down the hierarchical structure should be facilitated at every level.

- At each hospital, labour adjustment strategies be in place before downsizing of manpower takes place if these communities are to retain a skilled manpower resource.

- At each hospital, job descriptions be written which reflect the actual jobs, along with their roles and responsibilities, taking into consideration proper delineation of "non-nursing" duties.

- At each hospital, float nurses be seriously considered with the skills to meet the requirements of services being provided on evening and nights.

- At each hospital, analysis of nursing skills required and available be immediately carried out, including an examination of the ability of available staff to meet these requirements.

- At each hospital, a formal budget for staff development/education programs be developed.

- At each hospital, a formal education program be implemented to upgrade and maintain skills, and that the appointment of Clinical Instructors, preferably without other unrelated job duties, should be a priority.

- Prince Rupert, Terrace, and Kitimat hospitals examine the feasibility of developing a Regional Education Program. and investigate the possibility of negotiating with the Northwest Community College Nursing Program to provide suitable courses for identified requirements for advanced skills/education.

- At each hospital, the position of Quality Assurance Co-ordinator be a full-time appointment with appropriate education and support services to fulfil the job requirements.

- At each hospital, Nursing Education Committees be developed.

- All three hospitals, Prince Rupert, Terrace, and Kitimat, forge strong links with the Northwest Community College to minimize recruitment and retention problems with respect to Nursing personnel.

- Every effort be made in each hospital to improve labour relations by:

    - Conducting union/management meetings on a regular basis;
    - Improving ongoing communications; and
    - Resolving identified problems in a timely manner.

- Further layoffs at each hospital should not occur until such time as the Labour Adjustment Strategy is in operation.

- Each hospital, as part of its developing human resource function, develop a co-ordinated plan of action for introducing/ maintaining/improving effective educational staff training programs on an ongoing basis.

- Each hospital establish criteria for justifying the use of callback and overtime, and distinguish between emergency and non-emergency procedures.

- Each hospital monitor callback and overtime to ensure appropriate usage.
- Each facility develop a "boundaries document" which outlines the scope of the roles and responsibilities for the Board, Administration and Medical Staff.
- Each of the hospitals ensure that it has an effective Joint Conference Committee with representation from the Board of Trustees, Administration, and the Medical Staff.
- The equipment planning process at each hospital be reviewed to ensure that the needs of medical staff and hospital staff are identified and prioritized in an appropriate fashion.
- The finalized equipment list at each hospital be endorsed by the Medical Advisory Committee.
- Each hospital develop a policy precluding any equipment purchases unless they have been approved or unless acquisition of the equipment is of an emergency nature.
- Each hospital undertake an organized process of identifying appropriate Community Partnership Programs to make application for funding.
- Each hospital develop proposals clearly identifying the costs and benefits to be achieved through use of the Hospital Innovation Incentive Fund.
- Each hospital work closely with their regional team members to identify fiscal concerns.

5.0 COMMUNITY-BASED SERVICES

We recommend that:

- Each hospital develop standardized educational programs in conjunction with the Home Nursing Program. These programs should inform hospital nursing staff and physician staff regarding the appropriateness of Home Nursing Care.
- Each hospital institute educational home care/hospital/physician staff rounds to support increased utilization of Home Care Programs.
- The Prince George Alcohol and Drug Program, with support from the Ministry of Health, undertake a needs assessment for Alcohol and Drug Counsellors and Substance Abuse Prevention Workers in all three communities, with a view to increasing its staff complement.

- A Northwest Regional Detoxification/Residential Treatment Centre be established.

- The Prince George Alcohol and Drug Program, with support from the Ministry of Health, undertake a review of their clients' needs in all three communities so as to determine:
    - the appropriate location for a Northwest Regional Detoxification/Residential Treatment Centre, and
    - the services such a Centre should provide.

- The Ministry of Health review its funding methodology to ensure availability of outpatient occupational and physiotherapy services to each of the three communities.

- The Ministry of Health and Seniors Services review seniors' housing needs in all three areas and, with community involvement, develop a planned building schedule for affordable seniors' housing.

- Education of community health care providers (as to the services provided by other agencies) take place on an annual basis through joint in-service sessions, Health Care Forums, and/or by familiarization with the community publication entitled, "Community Resource Book".

6.0 IMPROVED CO-ORDINATION OF HEALTH PROGRAMS

We recommend that:

- Community Health Councils be established in Prince Rupert, Terrace, and Kitimat and that these Councils be given the responsibility for the overall co-ordination and management of health care programs and services.

- The Ministry of Health establish a co-ordinating office to integrate all Ministry of Health interaction with the Community Health Boards and that funding for all provincially-sponsored health services be provided on an integrated basis through this co-ordinating office.

- A regional co-ordinator be appointed under contract from the Ministry of Health for a period not to exceed three years and that this individual be assigned the responsibility of ensuring that greater community and regional co-operation in the health services in the Northwest is developed, including the development of Community Health Boards in Prince Rupert, Terrace and Kitimat.

7.2 LISTING OF SUGGESTIONS

The Review Team has separated suggestions and recommendations in that suggestions are identified as opportunities for further analysis and investigation, whereas recommendations are specific actions that the respective organizations need to take.

- Prince Rupert Hospital could potentially increase its laundry volume and revenues by submitting proposals to various agencies within the City of Prince Rupert to provide them with laundry service.

- The laboratory staff at Mills Memorial Hospital suggest that with the replacement of certain pieces of equipment their jobs could be made easier and more productive.

- It is suggested that Mills Memorial Hospital incorporate into its equipment planning process the development of appropriate work stations and equipment for Medical Records staff.

- It is suggested that routine workload assignments for Housekeeping staff at Mills Memorial Hospital be reviewed with input by the Housekeeping Supervisor and that every effort be made to not use those rooms on Paediatrics and Psychiatry which are intended to be vacant.

- An audible monitoring system at Kitimat General Hospital is warranted so staff can see and hear people as they enter the Emergency Department.

- Kitimat General Hospital should undertake a comparative analysis of the Radiology Department with its peer hospitals with the goal of improving productivity.

- Consideration needs to be given at Kitimat General Hospital to improving the space allocation for Physiotherapy services and to addressing productivity issues within the Department.

- Lack of computerization in the Medical Records Department at Kitimat General Hospital is noticeable and should be addressed since it limits productivity.

- Available equipment at Kitimat General Hospital is considered to be adequate with the exception of some laundry equipment which should be included in the equipment priorities of the hospital.

- It is suggested that Kitimat General Hospital undertake a review of the Materiel Management Service to ensure that it is organized and staffed appropriately.

- There is a perceived need for increased space for Mental Health staff in Terrace and Prince Rupert.

- It is suggested that a committee be established for the purpose of defining the appropriate range of Rehabilitation Services and staffing complement for the region.

APPENDIX 1

SCHEDULED COMMUNITY PRESENTATIONS

Prince Rupert's (Scheduled) Presentations:

Kim Horbach, representing Prince Rupert Health Action Committee
Peter Lester, representing Prince Rupert City Council
Russell Wiens, representing Prince Rupert Alcohol and Drug Services
Paddy Jones, representing himself
Bob Byson, representing Northcoast Assessment and Referral
Josie Mackey, representing Prince Rupert Home Support Association
Julie MacDonald, representing AIDS Prince Rupert
Colleen Fitzpatrick, representing Hospital Employees' Union
Margaret Harris, representing Prince Rupert Physiotherapy Clinic
Angenita Gerbracht, representing an Occupational Therapy Perspective
Rev. Michael Whimmer, representing Prince Rupert Ministerial Association
Barry Blyth, representing Prince Rupert Labour Council
Barb McKinney and Myrtice Alpert, representing Citizens for Equal Health Care

Terrace's (Scheduled) Presentations:

Alex Houlden, representing Terrace Regional Health Care Society
Bill McRae, representing Dr. R.E.M. Lee Hospital Foundation
Ruth Hallock, representing the City of Terrace (Alderperson)
Margaret Kukkola, representing Old Age Pensioners
David Lane, representing Dr. R.E.M. Lee Hospital Foundation
John Jensen, representing Terrace & Kitimat Labour Council
Norma King, representing herself
Dr. Jim Dunfield, representing himself
Elaine Pigeau, representing H.E.U./Joint Action Committee
Marie Cousins, representing B.C. Nurses' Union
Lorraine Jorden, representing herself
Pat Delaronde, representing herself
Julie Saraki, representing herself

Kitimat's (Scheduled) Presentations:

Detlef Beck, representing Healthy Communities
Beryl Hubbard, representing herself
Gordon Knight, a senior Kitimat resident
Cindy Russell, Sharon Johnston and Louise Weighton, representing Hospital Employees' Union
Cliff Madsen, representing Canadian Association of Smelter and Allied Workers, Local 1
Rick Thompson, representing himself
Mayor R. Wozney, representing District of Kitimat
Eric Sykes, representing Alcan
Luella Froess, representing herself
Mark Hawkins, representing himself
Dorothy Jones, a senior Kitimat resident
Kirk Ives, Ross Slezak, representing Canadian Association of Smelter and Allied Workers, National
Dr. Howard Mills, representing Kitimat General Hospital Medical staff
Ivan Ball, representing Methanex
Ruth Mueller, representing Health Sciences Association
Cindy Markwart, representing B.C. Nurses' Union

In addition, the Review Team would like to acknowledge and thank others not listed who made spontaneous presentations and contributed to the discussion and debate regarding issues in this review.

ADDENDUM

HEU MINORITY REPORT -- NORTHWEST REVIEW TEAM

The special review of the funding problems confronting Northwest hospitals has been a worthwhile process. It largely confirmed the public concerns which led to its appointment. For example, it endorses the widespread community call for improved community health services and Specialist Services. However, HEU believes that some of the recommendations do not go far enough to ensure full provision of quality health care to area residents.

The Funding Formula

Although the report documents specific problems in each of the facilities under review, it does not spell out one unavoidable conclusion: the Health Ministry's funding formula is a blunt financial instrument which has a devastating impact in this region. Closing beds by cutting funding does not produce better care. The HEU recommends that the funding formula be revised to ensure that regional facilities suffer no further cuts in services.

Labour Force Adjustment

The report makes a strong appeal for no further layoffs until a labour adjustment strategy has been implemented. The HEU endorses this appeal but would add that the program must apply to those affected by the 1991-92 budget crisis.

Cost-Saving Measures, Improved Services

The review report does not support the view that Northwest health care services are adequate. In fact, there are inadequate services in many areas. The Review Team has documented widespread examples of waste including excessive administrative staff, even while beds were being closed. The Team has recommended cost-saving measures which should be supervised by a regional co-ordinator over the next three years. These changes need to be matched by improved Specialist Services and increased community services. The HEU supports these proposals but would recommend, in the most forceful possible terms, that existing hospital services be maintained until the community is satisfied that all other recommended measures have been implemented.

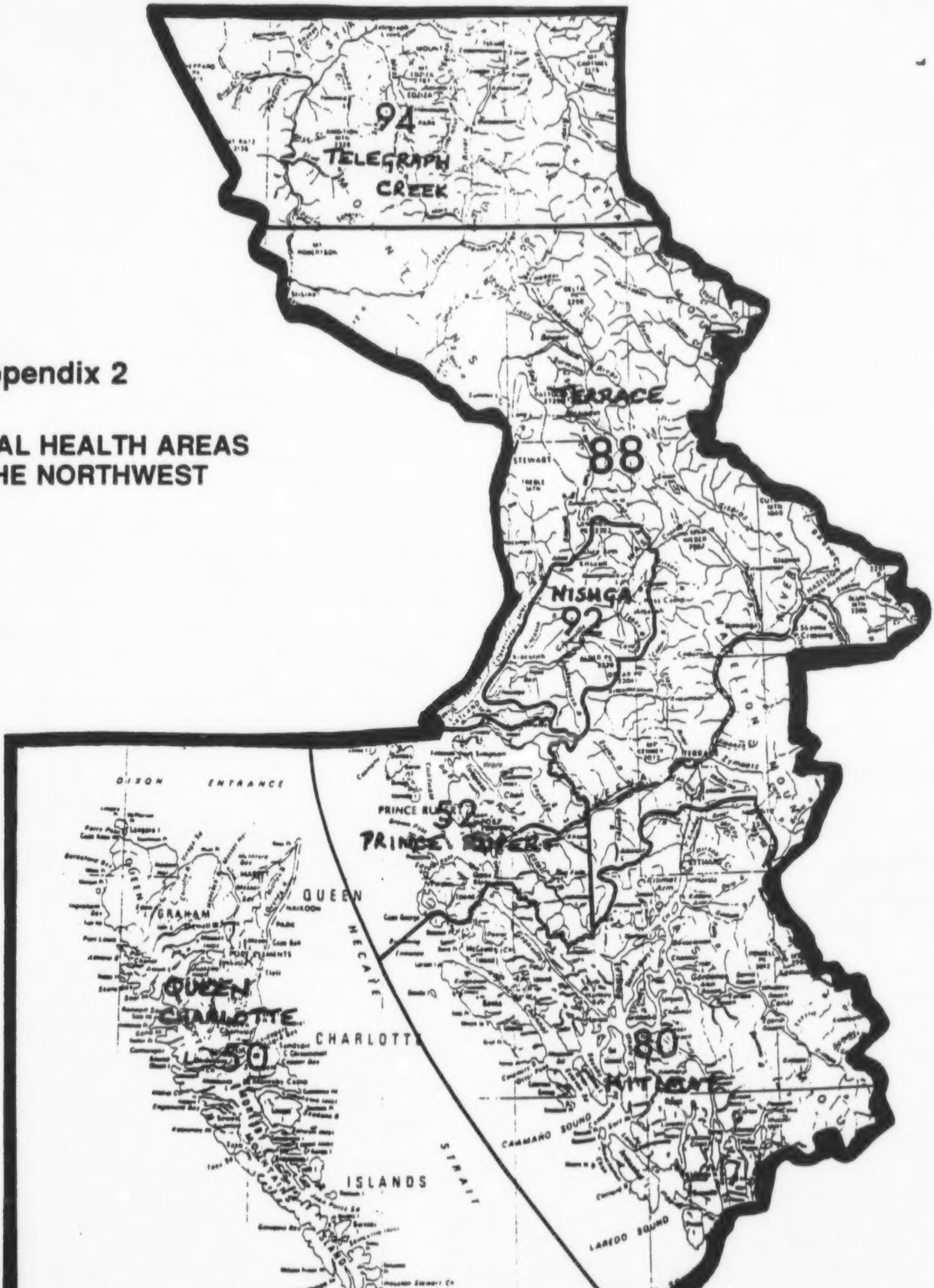
In conclusion, we believe the report makes a clear case for a change in Ministry policy. Continued budget freezes will result in reduction of services but will leave the underlying structural problems untouched. The Review Team's report confirms the need for substantial changes to re-shape health care services in the Northwest. It also proves the importance of a community-controlled planning process, including health care workers, to ensure that the changes do not come at the expense of high quality, universally-accessible health care.

Respectfully submitted,

Bella Maud
Representative, Hospital Employees' Union

Appendix 2

LOCAL HEALTH AREAS IN THE NORTHWEST


94
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TERRACE
88
STEWART
NISHGA
92
PRINCE RUPERT
52
PRINCE RUPERT
DIXON ENTRANCE
QUEEN CHARLOTTE ISLANDS
GRAHAM
HECATE STRAIT
QUEEN CHARLOTTE
50
80
KITIMAT
CAMMANO SOUND
LAREDO SOUND
MILBANKE SOUND